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No. 98 855

IN THE
Supreme Court of the United States
OCTOBER TERM, 1998

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN,
Petitioner,
v.
THE MARSHFIELD CLINIC and SECURITY
HEALTH PLAN OF WISCONSIN, INC.,
Respondents.

Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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118 pp

QUESTIONS PRESENTED

1. Whether a plaintiff that paid above-market prices to buy services from a seller that was engaged in a *per se* illegal division of markets with competitors may be denied the opportunity to seek damages from a jury because it has not produced evidence demonstrating to the court's satisfaction the precise amount of economic harm caused by the illegal conduct as opposed to other conduct found to be legal.

2. Whether an antitrust plaintiff that has successfully proved a *per se* violation of the Sherman Act may be denied the opportunity to present its damages claims to a jury based on the court's conclusion that the plaintiff's damages experts were not credible, even when the court acknowledged that the expert reports it rejected had used legally valid and appropriate scientific methodologies.

PARTIES IN THE COURT BELOW

The parties in the court below were as follows:

Blue Cross & Blue Shield United of Wisconsin
Compcare Health Services Insurance Corporation
The Marshfield Clinic
Security Health Plan of Wisconsin, Inc.

Blue Cross & Blue Shield United of Wisconsin is a Wisconsin corporation. It has no parent corporation. It has a partial ownership interest in United Wisconsin Services, Inc., a publicly traded Wisconsin company, which in turn owns Compcare Health Services Insurance Corp.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

TABLE OF AUTHORITIES vi

OPINIONS BELOW 1

JURISDICTION 2

STATUTES INVOLVED 2

STATEMENT OF THE CASE 2

REASONS FOR GRANTING THE WRIT 9

I. THE SEVENTH CIRCUIT'S DECISION ERRONEOUSLY IMPOSES A HEIGHTENED BURDEN OF PROOF ON ANTITRUST PLAINTIFFS TO SHOW THAT THE DAMAGES THEY ALLEGE COULD NOT BE ATTRIBUTABLE TO SOME ACTION OTHER THAN THE UNLAWFUL ACTION ESTABLISHED IN THEIR CASE 12

II. THE SEVENTH CIRCUIT MISAPPREHENDS THE ROLE OF THE COURT IN ACCEPTING THE REASONABLE INFERENCES OF EXPERT AND RELATED EVIDENCE 20

CONCLUSION 23

APPENDIX A:

Opinion, Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic, Nos. 97-3219 & 97-3847, U.S. Court of Appeals for the Seventh Circuit (filed July 30, 1998) 1a

TABLE OF CONTENTS—Continued

Page

APPENDIX B:

Opinion, Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic, Nos. 95-1965 & 95-2140, U.S. Court of Appeals for the Seventh Circuit (filed Sept. 18, 1995) (as amended on Oct. 13, 1995) 14a

APPENDIX C:

Order, Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic, Nos. 95-1965 & 95-2140, U.S. Court of Appeals for the Seventh Circuit (filed Oct. 13, 1995) 35a

APPENDIX D:

Opinion and Order, Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic, No. 94-C-0137-C, District Court for the Western District of Wisconsin (filed Sept. 10, 1996) 37a

APPENDIX E:

Order, Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic, No. 94-C-0137-C, District Court for the Western District of Wisconsin (filed Sept. 10, 1996) 49a

APPENDIX F:

Opinion and Order, Blue Cross and Blue Shield of Wisconsin v. Marshfield Clinic, 94-C-0137-C, District Court for the Western District of Wisconsin (filed April 1, 1997) 51a

APPENDIX G:

Opinion and Order, Blue Cross and Blue Shield of Wisconsin v. Marshfield Clinic, 94-C-0137-C, District Court for the Western District of Wisconsin (filed April 7, 1997) 71a

TABLE OF CONTENTS—Continued

APPENDIX H:

Page

Opinion and Order, Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic, No. 94-C-0137-C, District Court for the Western District of Wisconsin (filed July 28, 1997) 75a

APPENDIX I:

Order, Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic, Nos. 97-3219, 97-3847, U.S. Court of Appeals for the Seventh Circuit (filed Aug. 25, 1998) 84a

APPENDIX J:

Statutory Provisions Involved 85a

TABLE OF AUTHORITIES

CASES Page

Alleghany Pepsi-Cola Bottling Co. v. Mid-Atlantic Coca-Cola Bottling Co., 690 F.2d 411 (4th Cir. 1982) 14

Amerinet Inc. v. Xerox Corp., 972 F.2d 1483 (8th Cir. 1992) 15, 16

Bazemore v. Friday, 478 U.S. 385 (1986) 15

Bigelow v. RKO Radio Pictures, Inc., 327 U.S. 251 (1946) 5, 10, 13, 20, 21

Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic, 883 F. Supp. 1247 (W.D. Wis.), *aff'd in part and rev'd in part*, 65 F.3d 1406 (7th Cir. 1995) 3

Carmichael v. Samyang Tire, Inc., 131 F.3d 1433 (11th Cir. 1997), *cert. granted sub nom. Kumho Tire Co. v. Carmichael*, 118 S. Ct. 2339 (1998) .. 20

Catlin v. Washington Energy Co., 791 F.2d 1343 (9th Cir. 1986) 15

City of Vernon v. Southern California Edison Co., 955 F.2d 1361 (9th Cir. 1992) 14

Continental Baking Co. v. Old Homestead Bread Co., 476 F.2d 97 (10th Cir. 1973) 15

Continental Ore Co. v. Union Carbide & Carbon Corp., 370 U.S. 690 (1962) 21

Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993) 20

Engine Specialities, Inc. v. Bombadier Ltd., 605 F.2d 1 (1st Cir. 1979) 19

Farley Transportation Co. v. Santa Fe Trail Transportation Co., 786 F.2d 1342 (9th Cir. 1985) 14

Greater Rockford Energy and Technology Corp. v. Shell Oil Co., 998 F.2d 391 (7th Cir. 1993) 14

Isaksen v. Vermont Castings, Inc., 825 F.2d 1158 (7th Cir. 1987) 14

Litton Systems, Inc. v. American Telephone & Telegraph Co., 700 F.2d 785 (2d Cir. 1983) 13

National Farmers' Organization Inc. v. Associated Milk Producers Inc., 850 F.2d 1286 (8th Cir. 1988) 15, 19

TABLE OF AUTHORITIES—Continued

Page

Perma Life Mufflers, Inc. v. International Parts Corp., 392 U.S. 134 (1968) 13

Rossi v. Standard Roofing Inc., 156 F.3d 452 (3d Cir. 1998) 10, 15

SCM Corp. v. Radio Corp. of America, 407 F.2d 166 (2d Cir. 1969) 13, 14

Story Parchment Co. v. Patterson Parchment Paper Co., 282 U.S. 555 (1931) 13, 21

Sullivan v. National Football League, 34 F.3d 1091 (1st Cir. 1994) 15

William Inglis & Sons Baking Co. v. ITT Continental Baking Co., 668 F.2d 1014 (9th Cir. 1981) 16, 17

Yellow Pages Cost Consultants, Inc. v. GTE Directories Corp., 951 F.2d 1158 (9th Cir. 1991) 15

Zenith Radio Corp. v. Hazeltine Research, Inc., 395 U.S. 100 (1969) .... *passim*

STATUTES

Sherman Act, 15 U.S.C. §§ 1-2 .... *passim*

Clayton Act, 15 U.S.C. § 15(a) .... *passim*

28 U.S.C. § 1254(1) 2

MISCELLANEOUS

2 Phillip E. Areeda & Herbert Hovenkamp, *Antitrust Law* (1995) 16

Mark R. Patterson, *Coercion, Deception and Other Related Demand Increasing Practices in Antitrust Law*, 66 Antitrust L.J. 1 (1997) 22

M. Sean Royall, *Disaggregation of Antitrust Damages*, 65 Antitrust L.J. 311 (1997) 14

TABLE OF AUTHORITIES—Continued

Page

[illegible]

STATUTES

[illegible]

MISCELLANEOUS

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Respondents.

**Petition for Writ of Certiorari to the
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for the Seventh Circuit**

PETITION FOR WRIT OF CERTIORARI

Petitioner Blue Cross & Blue Shield United of Wisconsin ("Blue Cross") seeks review of a decision of the United States Court of Appeals for the Seventh Circuit affirming the denial of damages entered by Summary Judgment in the District Court for the Western District of Wisconsin.

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 152 F.3d 588 (7th Cir. 1998), and is reproduced at Pet. App. 1a. The order denying rehearing is reproduced at Pet. App. 84a. A prior decision of the Court of Appeals is reported at 65 F.3d 146 and reproduced at Pet. App. 14a.

Various memorandum opinions and orders of the District Court, on remand after the prior appeal, are unreported and reproduced as Appendices D through H.

JURISDICTION

The decision of the court of appeals was issued July 30, 1998. The order of the court of appeals denying a timely request for rehearing was issued on August 25, 1998. The Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1-2, and Section 4 of the Clayton Act, 15 U.S.C. § 15(a), are reproduced at Pet. App. 85a.

STATEMENT OF THE CASE

Marshfield Clinic, a large provider of medical services in north-central Wisconsin, violated Section 1 of the Sherman Act. Pet. App. 2a-3a, 14a-15a. A jury found the violation, the Seventh Circuit Court of Appeals affirmed the finding, and the district court entered a further Order on remand confirming a broad-based conspiracy between the fifth-largest physician clinic in the United States (with a quarter of a billion dollars in annual revenue) and numerous potential competitors. *Id.* at 40a-43a. This matter now comes to this Court after a second opinion of the Seventh Circuit incorrectly set standards for assessing damages in a Section 1 antitrust case.

This matter was tried to a jury in 1994-95. Petitioner claimed at the time that respondents had violated Sections 1 and 2 of the Sherman Act by dividing markets and fixing prices with competitors and by monopolizing the delivery of medical services in a manner that excluded competing health maintenance organizations from operating in certain Wisconsin counties. The jury found for plaintiffs and awarded damages. On appeal, in 1995, only the jury's finding of liability for dividing markets was affirmed by the Seventh Circuit. Pet. App. 32a. In affirming the liability, the court of appeals aptly noted:

> The analogy between price-fixing and division of markets is compelling. It would be a strange interpretation of antitrust law that forbade competitors to agree on what price to charge, thus eliminating price competition among them, but allowed them to divide markets, thus eliminating all competition among them.

Id. at 31a. Because the first jury did not award separate damages for claims reversed by the Court, the case was remanded to the district court for Blue Cross to show "how much less it would have paid the Clinic had the Clinic refrained from that illegal practice [*i.e.*, market division]." *Id.* at 33a.

On remand, Blue Cross followed accepted principles of calculation in preparing to demonstrate the amount of damages, utilizing both direct evidence and expert analysis. The direct evidence, much of it developed at the first liability trial, showed, for example, that Marshfield Clinic sold services to parties outside the area of the conspiracy for between 10% and 15% less than in the divided areas. (Tr. Exhs. 10320, 1968; R. 296, pp. 272-75) *See also Blue Cross and Blue Shield of Wis. v. Marshfield Clinic*, 883 F. Supp. 1247, 1259 (W.D. Wis), *aff'd in part and rev'd in part*, 65 F.3d 1406 (7th Cir. 1995). The defendant Marshfield Clinic even sold services to a Blue Cross joint venture, Valley Health Plan, at a lower price, because it was outside the area of the market division agreements. (R. 296, pp. 453-55; R. 431, p. 1088)

As further evidence of the damage amount, Blue Cross submitted the reports of two experts, Dr. John Beyer and Professor Thomas McGuire.

Professor McGuire, a nationally recognized health care economist, began his study by assuming the market division to be exactly as described by the Seventh Circuit and by defining the area of likely effect. He tested market power of the conspirators across a broad range of services by analyzing, statistically, their combined market shares. He found the conspirators together accounted for more than 70% of all the medical services in the affected areas (R. 699 at 18-21, exhs. 7-8). Having established study parameters, Professor McGuire then tested, through widely accepted statistical and regression methods, to determine if, as a general matter, there were disparities in the costs paid by Blue Cross within and outside this area on a per user basis. (R. 682 at 12-13) Not unexpectedly, given the proof of conspiracy, he found a statistically significant relationship.

Cognizant that quality of care might explain differences in cost, Dr. McGuire again used accepted techniques to test the relationship between quality and cost by establishing 1988 as a baseline year. (R. 682 at 13) By 1988, Marshfield's quality of care, case mix and other legal activities were in place. (*Id.*) The quality effect, already in place in 1988, could then be removed by examining changes in relationship with Marshfield's charges from 1988 forward. McGuire utilized overall cost by county and fixed-effects models commonly used in economic studies of health care costs (R. 733, ¶ 11, exh. 4; R. 807, ¶ 18)), so that Marshfield would be given the full benefit of any quality price premium. (R. 699 at 3-5, 28-29; R. 682 at 13-14; R. 775 at 11, 16-17).

Professor McGuire also controlled for a host of factors by taking into account the demographic characteristics of the population served by Marshfield. He compared county by county for the entire State of Wisconsin, utilizing multivariate regressions, to control for those differences in population mix. (R. 682 at 14, exhs. 7-8; R. 699 at 21-22 exh. 5) To further assure himself that case mix, *i.e.*, intensity of care, was not a factor in the substantial increases in Marshfield costs during the period of the conspiracy, Professor McGuire studied the physician mix at the Clinic and found the Clinic was becoming less sophisticated in its care between 1988 and 1994, the time of the conspiracy. (R. 699, exh. 6) In addressing the further possibility that Marshfield's large market share in the region might affect costs, the professor completed a regression study computing a standard HHI index for concentration and comparing again every county in the State. (R. 775 at 20) He found the relationship of his estimated damage amount and the conspiratorial conduct in the area was unaffected. (*Id.* at 21, exh. 11)

Based on his expert knowledge of the market for medical care, Professor McGuire concluded that it was appropriate to study not just the higher *prices* charged by Marshfield in the areas affected by the conspiracy, but the total cost per patient—thus including costs incurred when doctors ordered a higher *quantity* of services for given diagnoses. From his regression analyses, McGuire was able to determine a damage amount of $6.9 million (R. 699, exh. 4), or 14% of total payments during the affected period. This calculated amount was within the range already estimated by the direct evidence discussed above—*i.e.*, 10%-15%.

In order to test these results in yet a third way, Blue Cross engaged a second economics expert to calculate damages by using a "yardstick"—a long-accepted methodology for antitrust damage calculation. *Bigelow v. RKO Radio Pictures, Inc.*, 327 U.S. 251, 257-60 (1946). Dr. John Beyer chose a nearby area, Eau Claire, Wisconsin, where medical services comparable to those provided at Marshfield are available from providers that include a high-quality medical center—the Midelfort Clinic, owned by the renowned Mayo Clinic. As the quality of care was at least as high, due to the presence of a Mayo Clinic, in the comparable area, the study by its very nature controlled for quality, one possible alternative reason for higher prices. After studying the areas to assure comparability (R. 681 at 7-8), Dr. Beyer then compared the price charged by Marshfield to the price charged by others. He, too, found specific significant price differences. (R. 681 at 10-11; R. 766 at 4-5, tables 1-2)

In order to control for case mix, Dr. Beyer, through a series of computer analyses, grouped charges by like physicians providing like services. (R. 697 at 13-15, 17-20) To control for quantities, only amounts actually bought by Blue Cross were used in calculation. (R. 681 at 10, exh. 13)

Recognizing that Marshfield's large market share, even without the conspiracy, might be a factor in pricing, Dr. Beyer studied the relative market shares of Mayo's Midelfort Clinic in the comparison area, and found that its market share in the Eau Claire, Wisconsin area was at least as high as Marshfield's share in the area surrounding Marshfield, Wisconsin. (R. 766 at 4-5) When criticism was leveled about the need to compare Marshfield directly to a "comparable clinic," rather than an entire area, Dr. Beyer performed a direct comparison to Dean Clinic, a multispecialty clinic headquartered in Madison, Wisconsin, and he again found substantial overcharges by Marshfield. (*Id.* at 4) Finally, Dr. Beyer compared Marshfield to all physicians of identical specialties and case mix statewide, and again found a substantial and specific overcharge during the period of the conspiracy. (R. 681 at 8, 11; R. 766 at 8)

Having completed his study, Dr. Beyer estimated damages in a range of $6.7 million to $7.1 million, or 15% of the total paid by Blue Cross to Marshfield Clinic. (R. 766, ¶ 18) Again, these estimates fell within the range originally predicted based on the evidence of direct charges and discounts by the co-conspirators.

On the eve of the damages trial, defendants moved for summary judgment, arguing that petitioner's expert reports (1) improperly considered one category of petitioner's business and various product markets that were foreclosed from consideration after the prior trial and (2) did not separate out damages caused by the market division conspiracy. The district court initially treated the motion as a motion in limine and granted that motion. It questioned whether the experts had adequately considered the possibility that Marshfield's perceived higher quality of care might explain the payment differentials they identified, but the court did not rely on that ground. Pet. App. 64a-65a. Instead, it ruled that the experts' prospective testimony was inadmissible because it did not adequately separate out higher payments caused by conduct (other than market division) that the Seventh Circuit had found to be legal in the prior appeal. Pet. App. 65a.[1] But the court did not explain how it could square this conclusion with the various features of petitioner's experts' studies designed to do just that.[2] Six days later, the district court ruled that petitioner's direct (non-expert) evidence of damages was insufficient on its own and refused to delay the trial to allow petitioner's experts to address the concerns raised by the court. It accordingly granted summary judgment to respondents on the issue of damages, holding that petitioner's evidence failed to create even a triable issue with respect to the amount of injury caused by respondents' *per se* violation of the Sherman Act.[3]

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[1] The district court expressed skepticism about the fact that petitioner's experts claimed to have identified damages caused by the market division conspiracy more than ten times greater than the amount of damages—for a broader range of alleged misconduct—allowed to stand by the district court after the first trial (*i.e.*, $594,000). But that figure reflected the limitations on product markets and categories of petitioner's business that were a part of monopoly markets reversed earlier by the court of appeals. If those same limitations were applied to petitioner's experts' new reports, their claimed damages would be reduced to the same order of magnitude—approximately $700,000 to $1 million—even though they were studying a period of injury two years longer. There was thus no reason, based on the absolute amount of damages claimed as compared to the prior remittitur amount, to discredit petitioner's experts in any respect.

[2] The court also expressed "concerns" about Professor McGuire's reliance, not on price alone, but on payments per patient. Pet. App. 9a-10a. It noted that, in most markets, anti-competitive conduct results in a price increase and an output decrease. Pet. App. 9a. The court stated that McGuire "may be correct" in opining that

On appeal, the Seventh Circuit affirmed in relevant part, albeit not on all of the grounds cited by the district court. The Seventh Circuit acknowledged that price comparisons are a long-accepted methodology for measuring Section 1 damages. Pet. App. 6a. Without discussing any of the details of Dr. Beyer's work, other than to acknowledge that he had used a potentially valid "yardstick" methodology, the court dismissed that study for failing to be "properly adjusted." The court of appeals asserted that Beyer's study attributed "the entire difference between the prices of the Marshfield Clinic and the prices of other Wisconsin providers of medical services to the division of markets, with no correction for any other factor except differences in the treatment mix." Pet. App. 8a. As to Professor McGuire's extensive reports, which the court acknowledged were "more prom-

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medical markets operate differently, but held that he had "failed to show" that his approach is "generally accepted." Pet. App. 67a. In so doing, the court did not note the fact that it was a simple matter to extract from Professor McGuire's work a smaller, but still substantial, damages figure based on price differentials alone.

[3] In a subsequent order, the district court vacated its injunction barring future violations, on the theory that a party seeking to enjoin *per se* illegal conduct has to show actual injury. Pet. App. 80a. On appeal, the Seventh Circuit reinstated the injunction, on the ground that a party seeking injunctive relief need only show a likelihood of some injury. Pet. App. 3a-5a.

ising" Pet. App. 8a, the court of appeals concluded that he failed to adjust for proper increases in quantity of care (even though Professor McGuire statistically demonstrated untoward increases in quantity that caused, in part, the extraordinary costs paid by petitioner) and failed to adjust for possibly sicker patients. Pet. App. 9a-10a.

The Seventh Circuit opinion makes no reference to the summary judgment standard, no reference to the standard for evaluating damages claims, and no reference to the standard for evaluating statistical evidence and expert reports.

The court of appeals denied a petition for rehearing. Pet. App. 84a.

REASONS FOR GRANTING THE WRIT

This case raises an important question concerning the appropriate standard for determining whether an antitrust plaintiff who has successfully proved a *per se* violation of the Sherman Act has presented sufficient evidence of injury to survive a motion for summary judgment. Here, both parties' experts acknowledged that some quantum of damages flowed proximately from respondent's unlawful market-division conspiracy, and the court of appeals itself found it "likely" that petitioner had to pay higher prices as a result of the conspiracy. Nevertheless, the court declined to let the jury consider damages, because in its view petitioner's experts had not adequately considered the degree to which petitioner might also have been damaged as a result of other, lawful conduct.

In so ruling, the court of appeals confused two distinct "injury" issues that arise in private antitrust actions seeking damages, and the distinct burdens of proof that apply to each. First, as part of its prima facie case, a plaintiff must establish "some damage flowing from the unlawful conspiracy." *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100, 114 n.9 (1969) (citations omitted).

Concerning that issue, "courts apply the ordinary standard of proof," *Rossi v. Standard Roofing Inc.*, 156 F.3d 452, 484 (3d Cir. 1998), but there is no duty to specify the amount of injury; "proof of *some* [injury] flowing from the unlawful conspiracy" is sufficient. *Zenith,* 395 U.S. at 114 n.9 (emphasis in original). Once some injury is established, the plaintiff has the further duty to submit evidence showing the amount of damages it should be awarded, but as to that issue, "the ordinary standard of proof . . . is somewhat relaxed." *Rossi,* 156 F.3d at 484. The "jury may make a just and reasonable estimate of the damage based on relevant data," relying upon "probable and inferential, as well as . . . direct and positive proof," because "[a]ny other rule would enable the wrongdoer to profit by his wrongdoing at the expense of his victim." *Bigelow,* 327 U.S. at 264.

The legal question presented here is whether an antitrust plaintiff's failure to separate out, with convincing precision, the amount of damages caused by factors other than the illegal conspiracy is properly considered at the first stage of the analysis—as a basis for concluding (1) that the plaintiff has failed to establish "some injury" caused by the illegal acts and thus (2) that the plaintiff is not entitled to invoke the relaxed standard of proof applicable when the question is the *amount* of injury caused by those acts. Although it was undisputed that the Marshfield Clinic charged petitioner more than other Wisconsin providers charged during the period of the illegal market division, the Seventh Circuit concluded (erroneously in our view, *see* Part II *infra*) that petitioner had failed to surmount the first injury hurdle because its evidence did not sufficiently disaggregate the conspiracy from other factors—such as quality and market share—that might also have contributed to these added costs.

That was clear error. This Court has held that it "is enough that the illegality is shown to be *a* material cause of the injury; a plaintiff need not exhaust all possible alternative sources of injury in fulfilling his burden of proving compensable injury." *Zenith*, 395 U.S. at 114 n.9 (emphasis added). The reason is that, if an inability to separate the "material causes" with precision is treated as a failure to establish causation of some injury, the benefits of the relaxed standard of proof at the second stage will always be negated. Under the Seventh Circuit's approach, in any case where "direct and positive proof" of the specific amount of injury solely caused by the antitrust violation cannot be established with precision, the plaintiff will not be able to rely on a "reasonable and just estimate," as *Bigelow* mandates, because the lack of precision will be treated as a failure to establish *any* injury and the question of the amount of damages to be awarded will never arise. Because this approach is both wrong under this Court's governing precedents and typical of the confusion that has arisen in other similar cases in the lower courts, this Court should grant review to clarify the standards governing proof of damages claims under the antitrust laws.

The Court should also grant review to clarify the appropriate role of the court in assessing expert evidence of antitrust damages, prior to the presentation of that evidence at trial. The district court and the court of appeals in this case evinced a remarkable willingness to criticize as unconvincing, based on a paper record, expert studies that used methodologies the courts acknowledged to be standard in antitrust litigation. In so doing, they ignored the basic principle of Fed. R. Civ. P. 56 that the evidence of the party against whom summary judgment is sought must be accepted, rather than disregarded based on the conflicting evidence of the moving party.

I. THE SEVENTH CIRCUIT'S DECISION ERRONEOUSLY IMPOSES A HEIGHTENED BURDEN OF PROOF ON ANTITRUST PLAINTIFFS TO SHOW THAT THE DAMAGES THEY ALLEGE COULD NOT BE ATTRIBUTABLE TO SOME ACTION OTHER THAN THE UNLAWFUL ACTION ESTABLISHED IN THEIR CASE.

By the time of the rulings at issue here, it was established that respondents had entered into an illegal agreement to divide up the market with competitors, for the purpose of "charg[ing] higher prices to its customers." Pet. App. 4a. Given that *per se* violation of the Sherman Act, the Seventh Circuit noted that petitioner is "a major customer of the Clinic that is likely to have to pay higher prices." *Id.* It nevertheless declined to allow the jury to consider the question of damages against Marshfield because Blue Cross did not "prov[e] with the degree of precision required" the exact amount of the damages it suffered. *Id.* at 5a. In reaching this conclusion, the court rejected as legally inadequate two expert reports each concluding that Blue Cross paid almost $7 million more for services than it would have absent the conspiracy, because in the court's view those reports did not take sufficiently into account "[a]ny nonconspiratorial factors likely to have made the prices charged by the Marshfield Clinic higher than the prices charged by other health-care providers." *Id.* at 6a. The court reached this conclusion even though respondents' own experts acknowledged that the defendants' misconduct caused petitioner *some* damage, and even though it acknowledged that the petitioner's expert's statistical methods were "not improper". Pet. App. 6a.

An essential component of antitrust enforcement is the right of a private party to seek and obtain damages. As this Court has noted, "the purposes of the antitrust laws are best served by insuring that the private action will be an ever-present threat to deter anyone contemplating business behavior in violation of the antitrust laws. . . . [T]he law encourages [the private party's] suit to further the overriding policy in favor of competition." *Perma Life Mufflers, Inc. v. International Parts Corp.*, 392 U.S. 134, 139 (1968), *overruled on other grounds by Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984).

Because private damages suits play an important role in enforcing the Nation's antitrust laws, and because by their conduct antitrust violators often make it difficult or impossible to determine with precision the exact measure of the appropriate damages, the courts have long allowed juries to make "a just and reasonable estimate [of damages] based on relevant data," relying upon both "probable and inferential, as well as . . . direct and positive proof." *Bigelow*, 327 U.S. at 264. "If the damage is certain, the fact that its extent is uncertain does not prevent a recovery." *Story Parchment Co. v. Patterson Parchment Paper Co.*, 282 U.S. 555, 566 (1931). "Any other rule would enable the wrongdoer to profit by his wrongdoing at the expense of the victim. It would be an inducement to make wrongdoing so effective and complete in every case as to preclude recovery, by rendering the measure of damages uncertain." *Bigelow*, 327 U.S. at 264-65. "Accordingly, 'where there is a basis on which a jury can reasonably infer significant antitrust injury, [the court] should be very hesitant before determining that damages cannot be awarded.'" *Litton Systems, Inc. v. American Tel. & Tel. Co.*, 700 F.2d 785, 823 (2d Cir. 1983) (citation omitted).

This being so, "there is a clear distinction between the measure of proof necessary to establish the fact that petitioner had sustained some damage and the measure of proof necessary to enable the jury to fix the amount." *Story Parchment Co.*, 282 U.S. at 562; *Rossi*, 156 F.3d at 484. In determining whether the plaintiff has carried its burden of proving some injury, no matter how small, courts require plaintiffs to prove with "reasonable certainty" that injury has occurred. *SCM Corp. v. Radio Corp. of America,* 407 F.2d 166 (2d Cir. 1969). But in considering the precise amount of damages, courts apply the more relaxed standard.

Here, in the guise of applying the former requirement, the Seventh Circuit subjected petitioner's expert reports to the most rigorous review, and refused to allow the matter to proceed to the jury for a damages calculation because in the appellate court's view the experts had not properly considered all of the other possible reasons that could explain why plaintiffs had paid more than they should have for medical services. The Seventh Circuit thus treated the failure adequately to disaggregate injury claims as a threshold matter that goes to whether or not the plaintiff has proved any injury at all.

This approach is not unprecedented. Other courts similarly have found that a plaintiff's failure to disaggregate claims is fatal to their damages case, usually on the theory that failure properly to disaggregate claims would lead the jury to engage in undue speculation. *See, e.g., Greater Rockford Energy and Technology Corp. v. Shell Oil Co.,* 998 F.2d 391, 401-04 (7th Cir. 1993) (granting summary judgment because "plaintiff have failed to show with a fair degree of certainty that the antitrust violation was a material and substantial factor causing their alleged injuries"); *City of Vernon v. Southern California Edison Co.,* 955 F.2d 1361, 1372 (9th Cir. 1992); *Isaksen v. Vermont Castings, Inc.,* 825 F.2d 1158, 1165 (7th Cir. 1987) (judgment vacated when "there was no evidence of how much the antitrust violation, as distinct from unrelated market forces, contributed to [plaintiff's] losses"); *Farley Transp. Co. v. Santa Fe Trail Transp. Co.,* 786 F.2d 1342, 1350-52 (9th Cir. 1985); *Alleghany Pepsi-Cola Bottling Co. v. Mid-Atlantic Coca-Cola Bottling Co.,* 690 F.2d 411, 414-15 (4th Cir. 1982). *See generally* M. Sean Royall, *Disaggregation of Antitrust Damages,* 65 Antitrust L. J. 311 (1997).

On the other hand, other courts have been more faithful to this Court's precedents and concluded that to survive summary judgment a plaintiff "need only establish that [the defendant's] alleged violations had a tendency to injure [the plaintiff's] business, and [the plaintiff] suffered a decline in its business 'not shown to be attributable to other causes.' " *Amerinet, Inc. v. Xerox Corp.*, 972 F.2d 1483, 1495 (8th Cir. 1992). *See also Rossi*, 156 F.3d at 484; *Sullivan v. National Football League*, 34 F.3d 1091, 1105-06 (1st Cir. 1994) (not error to allow jury to consider expert report in antitrust case even though report left "much to be desired from the standpoint of a factfinder" because it failed to take into account "some important factors"); *Yellow Pages Cost Consultants, Inc. v. GTE Directories Corp.*, 951 F.2d 1158, 1163 (9th Cir. 1991) (plaintiff's claim not improperly speculative merely because its expert "conceded that other factors might have contributed to the revenue drop"); *National Farmers' Org., Inc. v. Associated Milk Producers, Inc.*, 850 F.2d 1286 (8th Cir. 1988); *Catlin v. Washington Energy Co.*, 791 F.2d 1343, 1347 (9th Cir. 1986) ("appellants need not rule out 'all possible alternative sources of injury,' [but], they must show that the alleged anticompetitive activity was 'a material cause of the injury' " (citation omitted)); *Continental Baking Co. v. Old Homestead Bread Co.*, 476 F.2d 97, 105 (10th Cir. 1973); *see also Bazemore v. Friday*, 478 U.S. 385, 400 (1986) ("Importantly, it is clear that a regression analysis that includes less than 'all measurable variables' may serve to prove a plaintiff's case. A plaintiff in a Title VII suit need not prove discrimination with scientific certainty.") (citation omitted).

The latter approach is clearly the correct one:

> [T]o require proof that the illegal conduct was the *exclusive* cause of the plaintiff's injury would effectively deny private remedies, for multiple causes always affect everyone. . . . It is therefore enough

> that the antitrust violation contributes significantly to the plaintiff's injury even if other factors amounted in the aggregate to a more substantial cause. . . . If the plaintiff's claim of causation is plausible, it should not be dismissed summarily merely because alternative causation stories are plausible as well.

2 Phillip E. Areeda & Herbert Hovenkamp, *Antitrust Law* ¶ 363a at 219-22 (1995). In an oft-quoted portion of the seminal *Zenith Radio* decision, the Court held that it is enough at the initial stage to show that illegal conduct was "*a* material cause of the injury; a plaintiff *need not exhaust all possible alternative sources of injury* in fulfilling his burden of proving compensable injury under § 4" of the Clayton Act. 395 U.S. at 114 n.9 (emphasis added). It went on to rule that the plaintiff had satisfied its burden by showing (1) illegal conduct and (2) financial injury of "precisely the type . . . that the claimed violations of the antitrust laws would be likely to cause," thus entitling the trial court to "infer from this circumstantial evidence that the necessary causal relation between the . . . conduct and the claimed damage existed." *Id.* at 125. *See also Amerinet*, 972 F.2d at 1495. Courts applying the more heightened standard, by contrast, require much more: that the plaintiff supply affirmative evidence that a specific quantum of injury was solely caused by the antitrust violation.

A good example of how *Zenith Radio* has been correctly applied in some lower courts is the Ninth Circuit's ruling in *William Inglis & Sons Baking Co. v. ITT Continental Baking Co.,* 668 F.2d 1014, 1051 (9th Cir. 1981)—a decision that directly conflicts with the instant case. There, the defendant argued that it had introduced evidence "showing the existence of factors other than its own pricing activity which contributed to Inglis' failure as a business." *Id.* The court said that this evidence was insufficient to bar a claim for damages, even though the plaintiff could not separate out the precise effects of the illegal conduct and these other "factors":

> Inglis' demise was, in our view of the record, the result of a confluence of factors. In such circumstances it is difficult to identify precisely the extent to which the failure was the result of allegedly illegal conduct. However, the law does not require precision in this area. Continental's pricing need only have been a material cause of Inglis' decline, and causation may be inferred if Inglis' injury was "the type of loss that the claimed violations of the antitrust laws would be likely to cause."

Id. (quoting *Zenith Radio,* 395 U.S. at 125).

The reason for this kind of flexibility is that, without it, the first stage of the injury analysis—the showing of causation of "some injury"—swallows up the second—the showing of an amount of injury. At the second stage, the courts are solicitous of the difficulties facing plaintiffs attempting to show how much of their injuries were caused by illegal conduct as opposed to other factors, and apply a relaxed standard of proof in order to prevent defendants from avoiding financial responsibility for acts that were illegal and played a role in creating the very uncertainty at issue. But if those same difficulties lead to a finding that no "injury" has been proved at the outset, the relaxed standard will never come into play and defendants will be beneficiaries.

There could be no better example of this phenomenon than this case. In view of the fact that Marshfield charged extraordinarily high prices during the period of the conspiracy and those prices were limited to the area of the conspiracy, little more should have been required to justify the inference that the conspiracy was "a material cause of the injury." Indeed, both parties' experts agreed that there was material injury, and even the Seventh Circuit held that such injury was "likely." Yet the same court required petitioner to do exactly what the *Zenith* Court forbade—to "exhaust all possible alternative sources of injury" in order even to get the *opportunity* (under the *Bigelow* relaxed standard) to show the amount of damages to which it was entitled.

This outcome was particularly remarkable because petitioner did *not* rely solely on an inference of injury based on Marshfield's high prices and the prior finding of an anti-competitive market-division agreement. Petitioner supplied expert reports that directly addressed, in different but hardly unprecedented ways, the difficult problem of isolating the economic effects of such an agreement. Dr. Beyer did so by examining a whole variety of "yardstick" providers, whom he had studied and was prepared to defend as comparable in quality, market share, case mix, and similar factors. Professor McGuire did so by (1) studying only relative changes in health care costs dating from the beginning of the conspiracy (thus effectively controlling for Marshfield's pre-existing reputation for quality) and (2) including in his regression studies a variety of additional variables addressing other potential causative factors. *See* pp. 3-5 *supra.*

Yet the Seventh Circuit found these studies insufficiently persuasive, in large part because both experts' damages estimates were similar to estimates made at an earlier phase of the case when there were additional antitrust allegations considered—charges that were ultimately dismissed. And it was on that point that the erroneous legal analysis of the court of appeals became most stark. The court acknowledged that "it is possible that the alleged violations were redundant . . . the Marshfield Clinic may have stacked the division of markets on top of other practices any one of which would have had the same effect on its customer's prices." Pet. App. 8a-9a. In the court's view, however, "this observation cannot help Blue Cross," because in order for it to be able to recover damages, it must establish that the violation it proved is the *exclusive* cause of the injury it alleges. *Id.* at 9a. "If [the illegal division of markets] added nothing to the price effects of the legal practices, it did not cause Blue Cross any harm." *Id.*

Such analysis takes to its extreme the reasoning of those courts that have dismissed damages claims because they are insufficiently disaggregated, *see supra,* p. 14, allowing the plaintiff to present its damages claim to the jury only if the established violation alone could be proved to be uniquely responsible for some specific portion of plaintiff's loss. But that analysis conflicts generally with those cases that more faithfully follow this Court's teaching in *Zenith Radio* that "a plaintiff need not exhaust all possible alternative sources of injury." 395 U.S. at 114 n.9. *See Engine Specialties, Inc. v. Bombardier Ltd.,* 605 F.2d 1, 14 (1st Cir. 1979) ("Plaintiffs need not prove that the antitrust violation was the sole cause of their injury, but only that it was a material cause."). And, it conflicts directly with the law of the Eighth Circuit, which addressed the same situation and reached the opposite result:

> An antitrust plaintiff's damage claim is not . . . rendered speculative or unreasonable merely because it fails to provide for a specific reduction in the event that allegations of certain unlawful conduct are rejected. . . . [I]f an antitrust plaintiff alleges that the defendant engaged in unlawful acts A, B, C, and D, and acts C and D are later rejected as a basis of liability, it does not automatically follow that the damages award must be reduced. Rather, if acts A and B support the entire damage award, it must be sustained.

National Farmers' Org., 850 F.2d at 1307.

The Court should grant this petition to bring uniformity to the different legal rules of the courts of appeals on this important question of federal law.

II. THE SEVENTH CIRCUIT MISAPPREHENDS THE ROLE OF THE COURT IN ACCEPTING THE REASONABLE INFERENCES OF EXPERT AND RELATED EVIDENCE.

The recent cases before this Court concerning expert witnesses and the role of the court in evaluating that evidence for scientific efficacy, *see Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993); *Carmichael v. Samyang Tire, Inc.*, 131 F.3d 1433 (11th Cir. 1997), *cert. granted, sub nom. Kumho Tire Co. v. Carmichael*, 118 S. Ct. 2339 (1998), have focused attention on the proper role of the district court in evaluating expert evidence outside the presence of the jury. Those decisions, however, do not alter the important balance established by Rule 56 of the Federal Rules of Civil Procedure, which preserves for the fact-finder the resolution of all genuine disputes of material fact.

Here, contrary to the Rule 56 standard, the court of appeals and the district court misapprehended their respective roles and, without considering *Daubert*, nonetheless rejected as a matter of law two thorough expert studies, even though they acknowledged that the basic methodologies used were legally valid and even though the studies were buttressed by confirming direct evidence. It is important for this Court, having recently expressed concern about the scientific validity of expert testimony, to review this matter in order to make clear that a summary judgment motion is not an invitation for courts to begin assessing the relative persuasiveness of competing expert opinions based on a mere paper record. This is particularly appropriate in the context of antitrust damages where the standard for measurement is more relaxed than the standard for measuring liability. *Zenith Radio*, 395 U.S. 100; *Bigelow*, 327 U.S. 251.

To begin with, both the district court and the court of appeals parsed the evidence into distinct categories—direct evidence, Dr. Beyer's expert analysis and Professor

McGuire's expert analysis. Then, each court dissected those items of proof. Such separation of the individual items of evidence is plainly contrary to the law. As this Court noted, in Section 1 conspiracy cases, "plaintiffs should be given the full benefit of their proof without tightly compartmentalizing the various factual components and wiping the slate clean after scrutiny of each." *Continental Ore Co. v. Union Carbide & Carbon Corp.*, 370 U.S. 690, 699 (1962).

In damage calculation, as here, the rules requiring consideration of of all the evidence and the fairly derived inferences are not mere guides. "Trial and appellate courts alike *must* also observe the practical limits of the burden of proof which may be demanded of a treble-damage plaintiff who seeks recovery for injuries . . . damage issues in these cases are rarely susceptible of the kind of concrete, detailed proof of injury which is available in other contexts." *Zenith Radio*, 395 U.S. at 123 (emphasis added). For the court of appeals to do as it did here, parsing and splitting the evidence, sets a precedent contrary to the long history of antitrust law, *see id.* at 123-25; *Continental Ore*, 370 U.S. at 698-99; *Bigelow*, 327 U.S. at 264; *Story Parchment*, 282 U.S. at 561-64, fundamentally altering the balance between the obligations of the antitrust plaintiff and defendant by refusing to accept as true the findings of scientifically valid studies.

A more specific example of the overreaching of the courts below is their treatment of Professor McGuire's prospective testimony that illegally obtained market power in the provision of medical services can inflate the *quantity* of services provided as well as their *price*. Both courts expressed skepticism about this conclusion, noting that it departs from the usual pattern in other kinds of markets. Pet. App. 9a-10a, 66a-68a. But Professor McGuire has great experience and expertise with health care economics and was fully prepared to testify, if given the chance, about the valid basis of his opinion. The matter of demand inducing antitrust violations has been the subject of substantial legal and scholarly analysis. *See, e.g.*, Mark R. Patterson, *Coercion, Deception and Other Related Demand Increasing Practices in Antitrust Law*, 66 Antitrust L.J. 1 (1997).

Moreover, both courts blithely asserted that there was no evidence Marshfield had increased the quantity of its services when it divided markets. Yet Professor McGuire's study itself addressed in statistical analysis (multivariate regression) that very question of unnecessary procedures, found a history of additional charges by Marshfield not charged by others (R. 682 at 12-14), and observed no outcome difference for the patients. (R. 699 at 13-14) Professor McGuire pointed as well to other experts who cited specific proofs and expert analysis concerning a *lower* quality outcome. (*Id.*) The conclusion that Marshfield Clinic's overcharges were masked in the form of additional procedures was most certainly a just and reasonable inference. Finally, Professor McGuire made clear that, even absent the phenomenon of quantity increases, his study showed substantial damages to Blue Cross based on price alone.

It is important to recognize, in this regard, that the expert studies at issue did specifically address the very factors—other than the illegal market division conspiracy—that the courts below said had not been adequately ruled out as alternative explanations of the payment differentials received by Marshfield. It is undeniable that both McGuire and Dr. Beyer addressed quality of care, market share, treatment mix, and other legal factors in their respective reports. *See* pp. 3-6 *supra*. The district court and court of appeals disagreed with those reports and believed they did provide "enough." But such disagreements are for the trier of fact, not the court acting on a motion for summary judgment. The mere presence of experts does not enhance the role of the judge in a case to be tried to a jury.

The Court must provide guidance as to the applicable standards for review of expert studies, in conjunction with other evidence. This case provides a clear opportunity to examine those issues as the matter is before this Court on a specific summary judgment limited to a single issue —damages.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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APPENDIX A

UNITED STATES COURT OF APPEALS
SEVENTH CIRCUIT

Nos. 97-3219, 97-3847

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Plaintiffs-Appellants,

v.

MARSHFIELD CLINIC, *et al.*,
Defendants-Appellees.

Argued June 5, 1998
Decided July 30, 1998

Before POSNER, Chief Judge, and BAUER and KANNE, Circuit Judges.

POSNER, Chief Judge.

This is the second round of appeals in an antitrust case brought by a health insurer against a medical clinic. See 65 F.3d 1406 (7th Cir.1995). The defendant, the Marshfield Clinic in rural Wisconsin, is the dominant provider of medical services in the north-central part of that state; indeed, despite its remote location, it is one of the largest medical clinics in the nation, comparable in size to the Mayo and Cleveland clinics. Blue Cross of Wisconsin (together with its HMO) sued the Marshfield Clinic (and its HMO), alleging a variety of antitrust violations centered on the contention that the Clinic had illegally monopolized the provision of certain medical services in its region, enabling it to jack up its prices for those services above competitive levels to the detriment of Blue Cross, which pays the Clinic to treat patients insured by Blue Cross. The plaintiffs won a $20 million damages judgment (most of it in favor of Blue Cross's HMO rather than Blue Cross itself) and an injunction. The Clinic appealed, and we threw out all but one of the charges. That was the charge that the Clinic had divided markets with some of its competitors, that is, had agreed with them to keep out of each other's service areas. *Id.* at 1415-16. The evidence in support of this charge was sufficient for us to "conclude that the jury verdict on liability must stand insofar as the charge of a division of markets is concerned," to direct that the district court revise the injunction to confine it to that practice, and to order "a new trial limited to damages for dividing markets." *Id.* at 1416. (Neither HMO is involved in the division of markets charge, so we shall not refer to them any more.) We explained that at the new trial the "burden will be on Blue Cross to show how much less it would have paid the Clinic had the Clinic refrained from that illegal practice." *Id.*

On remand, following additional discovery, the district judge granted summary judgment for the Clinic on the ground that Blue Cross had produced no evidence that it had suffered any injury as a result of the division of markets. 980 F.Supp. 1298 (W.D.Wis.1997). In the same order she ruled that Blue Cross was not entitled to an award of attorneys' fees, since it was not the prevailing party; and later she awarded the Clinic its court costs of some $220,000. So this time Blue Cross has appealed. It argues that it is entitled to an injunction even if it cannot prove damages; that it can prove damages; and that it should be adjudged a prevailing plaintiff and hence awarded a reasonable attorney's fee and court costs (see

Clayton Act, § 4, 15 U.S.C. § 15(a)) and not have to pay its opponent's costs.

Blue Cross is clearly right with regard to the injunction. We held when this case was last before us that the jury's finding on liability for dividing up the market with its competitors must be upheld and that Blue Cross was entitled to an injunction against that practice. This holding established the law of the case, binding the district judge on remand and us on this subsequent appeal unless we have good reasons to depart from the previous decision. *Agostini v. Felton,* 521 U.S. 203, ——, 117 S.Ct. 1997, 2017, 138 L.Ed.2d 391 (1997); *Messenger v. Anderson,* 225 U.S. 436, 444, 32 S.Ct. 739, 56 L.Ed. 1152 (1912) (Holmes, J.); *Best v. Shell Oil Co.,* 107 F.3d 544, 546 (7th Cir.1997). We don't. Even though, as we shall see, the district judge was correct that Blue Cross has failed to come up with evidence that would authorize an award of damages for the division of markets, this does not justify withholding an injunction—rather the contrary. Inadequacy of a plaintiff's remedy at law, that is, his damages remedy, is normally (and so under section 16 of the Clayton Act, see 15 U.S.C. § 26, which authorizes an injunction in a private antitrust suit "when and under the same conditions" in which it would be granted by "courts of equity") a prerequisite to the entry of an injunction. *Walgreen Co. v. Sara Creek Property Co.,* 966 F.2d 273, 274 (7th Cir.1992). And a common reason why the damages remedy is inadequate is that the plaintiff is unable to quantify the harm that the defendant's practice has inflicted or will inflict on him. *Miller v. LeSea Broadcasting, Inc.,* 87 F.3d 224, 230 (7th Cir.1996); *Roland Machinery Co. v. Dresser Industries, Inc.,* 749 F.2d 380, 383 (7th Cir.1984).

The jury found on sufficient evidence that the Marshfield Clinic entered into agreements with competitors to stay out of each other's territories. The purpose was to enable each of the firms, prominently including the Clinic, to charge higher prices to its customers. It is true that a by-product of such an agreement might be to reduce the advertising and other marketing expenses of the conspirators, and the reduction might even be so great that the optimal monopoly price of each of the noncompetitors would be lower than the former competitive price, since a monopolist will charge a lower price the lower his costs are. The agreement would still be illegal; divisions of markets are per se illegal, just like price-fixing agreements, *Timken Roller Bearing Co. v. United States,* 341 U.S. 593, 71 S.Ct. 971, 95 L.Ed. 1199 (1951); but as it would be harmless, there would be no basis for a consumer's seeking an injunction. Indeed, a rational consumer would not seek an injunction that would lead to his having to pay *higher* prices.

Blue Cross was not, however, required to negate the remote possibility that the division of markets was a form of benign cartel (especially since the point was not argued by the defendant). And if this possibility is therefore set to one side, we have a major customer of the Clinic that is likely to have to pay higher prices unless the division of markets is enjoined. It is also possible, of course, that the defendant has abandoned the unlawful practice, perhaps induced to do so by the filing of the lawsuit; and in that event Blue Cross wouldn't need an injunction. But this possibility would not justify the withholding of the injunction without a degree of proof (of abandonment with no likelihood of resumption), see, e.g., *United States v. Oregon State Medical Society,* 343 U.S. 326, 333, 72 S.Ct. 690, 96 L.Ed. 978 (1952); *Wilk v. American Medical Ass'n,* 895 F.2d 352, 367 (7th Cir.1990), that the Clinic has not attempted.

What is true and misled the district judge is the principle that there is no tort without an injury. E.g., *Janmark, Inc. v. Reidy,* 132 F.3d 1200, 1202 (7th Cir.1997); *Rozenfeld v. Medical Protective Co.,* 73 F.3d 154, 156 (7th Cir.1996). A private suit under the antitrust laws is a suit seeking relief against a statutory tort, and the principle that there is no tort without an injury is applicable to it. See Clayton Act, § 4, 15 U.S.C. § 15(a). But all that this implies, so far as equitable relief is concerned, is that a plaintiff has to prove that he is likely to be harmed by the defendant's wrongful conduct unless that conduct is enjoined. This is clear from the text of the Clayton Act, which, evoking traditional principles of equity, *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100, 130, 89 S.Ct. 1562, 23 L.Ed.2d 129 (1969), requires proof only of "*threatened* loss or damage." Clayton Act, § 16, 15 U.S.C. § 26 (emphasis added); see *California v. American Stores Co.*, 495 U.S. 271, 282 n. 8, 110 S.Ct. 1853, 109 L.Ed.2d 240 (1990); *Ohio-Sealy Mattress Mfg. Co. v. Sealy, Inc.*, 585 F.2d 821, 844 (7th Cir.1978). There is sufficient evidence of that here. Blue Cross bought services from a seller that had agreed with other sellers to refrain from competing for customers, and it is likely, whether or not provable with the degree of precision required to ground an award of damages, that unless the defendant is enjoined Blue Cross will have to pay Marshfield Clinic more than if the Clinic were not a member of an anti-competitive conspiracy directed in part against the plaintiff, the conspiracy that the suit seeks to destroy.

A more difficult question is whether the judge was right to conclude that Blue Cross could not prove what damages it had sustained as a result of the division of markets. The usual way to measure damages in such a case would be to compare the prices that the Marshfield Clinic charged Blue Cross before and during the conspiracy, or inside and outside the region covered by the conspiracy, or during the conspiracy and after it ended (if it has ended—the injunction issued by the district court before the first appeal was in effect for less than six weeks before we stayed it pending the appeal), correcting by various statistical techniques for any nonconspiratorial factors that might have caused the prices that are being compared to be different from each other. See *Isaksen v. Vermont Castings, Inc.*, 825 F.2d 1158, 1165 (7th Cir. 1987); *New York v. Hendrickson Bros., Inc.*, 840 F.2d 1065, 1078 (2d Cir.1988); *Home Placement Service, Inc. v. Providence Journal Co.*, 819 F.2d 1199, 1205 n. 7 (1st Cir.1987); *Phillips v. Crown Central Petroleum Corp.*, 602 F.2d 616, 632 (4th Cir.1979); 1 American Bar Association Section of Antitrust Law, *Antitrust Law Developments (Fourth)* 787 (4th ed.1997). This method or congeries of methods was unavailable to Blue Cross, however, because the division of markets embraced the entire period and region in which the necessary data are obtainable; at least Blue Cross made no effort to show otherwise. Instead it compared the Marshfield Clinic's prices for medical services between 1988 and 1995 with the prices charged by other providers of medical care for the same services during the same period elsewhere in Wisconsin, on the theory that those other prices, properly adjusted, are what Blue Cross would have had to pay the Clinic and the Clinic's competitors had it not been for the conspiracy.

This—the so-called "yardstick" method of computing antitrust damages—was not improper. *In re NASDAQ Market-Makers Antitrust Litigation,* 169 F.R.D. 493, 521 (S.D.N.Y.1996). But the qualification "properly adjusted" is at least as vital as when the plaintiff is trying to prove damages by comparing the defendant's prices at one period or in one area with its prices in another period or another area rather than (as under the yardstick approach) comparing the defendant's prices with the prices of other sellers. See, e.g., *Package Shop, Inc. v. Anheuser-Busch, Inc.*, 675 F.Supp. 894, 947-52 (D.N.J. 1987). Any nonconspiratorial factors likely to have made the prices charged by the Marshfield Clinic higher than the prices charged by other health-care providers had to be taken into account in order to make a responsible estimate of the prices that Blue Cross would have paid had it not been for the conspiracy. *Isaksen v. Vermont Castings, Inc., supra*, 825 F.2d at 1165.

The most important factors were the amount and quality of the Marshfield Clinic's service and its market share. The significance of market share is that even though the Marshfield Clinic was not proved to have monopoly power, it does have a large market share throughout north-central Wisconsin, which might confer enough market power on it to enable it all by itself, without dividing markets with its competitors, to charge a price somewhat above the average for the state. The larger a firm's market share is, the larger is the percentage increase that the other firms in the market must make in their output in order to offset the effect of the firm's curtailing its output in order to drive the market price above the competitive level. For example, if a firm has 50 percent of the market and as a corollary to jacking its price above the existing, competitive level reduces its output by 20 percent (say from 1,000 to 800 units), the other firms will have to increase their output by an average of 20 percent (from 1,000 to 1,200 units) in order to offset completely the reduction in the output of the dominant firm. This may be difficult for them to do at least in the near term, and so the dominant firm, though not a monopolist, will be able to get away, at least for a time, with its price hike. See George J. Stigler, "The Dominant Firm and the Inverted Umbrella," in Stigler, *The Organization of Industry* 108 (1968). That may have been the situation of the Marshfield Clinic.

To make the necessary corrections and thus establish that there was enough evidence to enable a jury to make a responsible estimate of damages, Blue Cross submitted to the district court multiple reports by two economic experts, John Beyer and Thomas McGuire. Beyer's two reports, which compute a range of damages exceeding

$7 million from the division of markets, are worthless. They attribute the entire difference between the prices of the Marshfield Clinic and the prices of other Wisconsin providers of medical services to the division of markets, with no correction for any other factor except differences in the treatment mix. Statistical studies that fail to correct for salient factors, not attributable to the defendant's misconduct, that may have caused the harm of which the plaintiff is complaining do not provide a rational basis for a judgment. *Milwaukee Branch of NAACP v. Thompson,* 116 F.3d 1194, 1198 (7th Cir.1997); *Kuhn v. Ball State University,* 78 F.3d 330, 332-33 (7th Cir.1996); *Schiller & Schmidt, Inc. v. Nordisco Corp.,* 969 F.2d 410, 415-16 (7th Cir.1992); *Tagatz v. Marquette University,* 861 F.2d 1040, 1044-45 (7th Cir.1988); *MCI Communications Corp. v. American Tel. & Tel. Co.,* 708 F.2d 1081, 1164-65 (7th Cir.1983); cf. *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.,* 509 U.S. 209, 242, 113 S.Ct. 2578, 125 L.Ed.2d 168 (1993); *J. Truett Payne Co. v. Chrysler Motors Corp.,* 451 U.S. 557, 563-67, 101 S.Ct. 1923, 68 L.Ed.2d 442 (1981); *Navarro v. Fuji Heavy Industries, Ltd.,* 117 F.3d 1027, 1031 (7th Cir.1997).

McGuire's reports are more promising, though as his bottom line is a damages figure only $11,000 below the lower of Beyer's highest two estimates, it is a little hard to take seriously. For how is it that after making the subtractions that Beyer failed to make, McGuire came up with essentially the same figure? And is it purely a coincidence that this number, after trebling, would give Blue Cross the same $20 million judgment (actually a little more) that it won in the first trial, even though the division of markets was among the least important of the many antitrust violations charged in this suit? Of course it is possible that the alleged violations were redundant; like the assassins of Rasputin, who drowned him after poisoning and shooting him in order to make sure he was really dead, the Marshfield Clinic may have stacked the division of markets on top of other practices any one of which would have had the same effect on its customers' prices. But this observation cannot help Blue Cross. For only one of the practices was illegal, the division of markets. If it added nothing to the price effects of the legal practices, it did not cause Blue Cross any harm.

The main reason that McGuire came up with such a high estimate of his client's damages from the division of markets is that he compared the prices charged by the Marshfield Clinic with the prices charged by other providers on the basis of price per patient (correcting for differences in the treatment mix), rather than price per service. The result of this procedure was that if Marshfield Clinic provided on average more treatment per patient than other providers, the difference was attributed to the division of markets. This is a strange inversion of the usual logic of cartelization, which is that cartelists drive up the market price by (or with the effect of) restricting their output, as in our numerical example. In defense of his procedure, McGuire pointed out that one way in which the Marshfield Clinic may be exploiting market power conferred upon it by the conspiratorial division of markets is by inducing patients to undergo unnecessary procedures paid for by Blue Cross. This is a possibility, but there is no evidence of it, and so it cannot provide the basis for calculating the damages due to the division of markets. To see this, imagine that in a suit for the breach of a building contract the plaintiff proved that the defendant had substituted an inferior grade of roofing. The plaintiff could not obtain damages for the defendant's having installed an inferior grade of plumbing, on the ground that the defendant *might* have done that as well. The plaintiff would have to present evidence that the defendant *did* do it. It is not as if fraud were a conventional method of exploiting monopoly power and so could be presumed; and if Blue Cross's real gripe is that the

Marshfield Clinic defrauded it, why isn't there a fraud count in the complaint?

McGuire did try to correct for differences in the quality of the services rendered by the Marshfield Clinic compared to the statewide average; but quality and quantity are not the same. If the Clinic because of its reputation (emphasized by Blue Cross itself) for high quality gets referred to it patients who are sicker than average and so require longer treatment, the average price per patient will be higher simply as a function of the more extensive or protracted care required on average by a sicker patient. As far as the record discloses, this is all there is to the higher average price per patient charged by the Marshfield Clinic. McGuire also failed to correct for the effect of market share on the Clinic's prices. In sum, no reasonable jury could estimate the plaintiff's damages from the reports of the plaintiff's experts.

In addition to those reports, there is some nonexpert evidence of damages, consisting of discounts of 15 or 20 percent that the Clinic gave to some of its coconspirators. But this evidence would not enable a reasonable jury to estimate the plaintiff's damages either. The discounts were given in exchange for bulk referrals, and there is no evidence that customers of the Marshfield Clinic, even so large a customer as Blue Cross, would have gotten equivalent discounts had the clinic been competing rather than conspiring. They might have, but no evidence was presented that they probably would have.

We are not saying that Blue Cross did not in fact lose any money as a result of the division of markets. It may well have, as we suggested in discussing the issue of the injunction. (But remember that there is a difference between an actual and a threatened harm. And there is also, and here critically, a difference between an actual and a quantifiable harm and also between a quantifiable and a quantified harm—and only the last supports an award of damages.) The Clinic's own economic experts estimated that the division of markets may have caused the Clinic's prices to be between .4 and .9 percent higher than they would otherwise have been. Blue Cross, however, did not cite that estimate in its briefs to us, and this raises an interesting question of waiver or forfeiture.

The omission to cite a specific item of evidence to an appellate court is ordinarily not a waiver of anything; parties have no obligation to bombard us with record citations. But it is not clear that a party's approach to calculating damages should be treated as evidence, rather than as theory or argument and hence as waived unless mentioned. And in any event silence about a critical piece of evidence can be and here is eloquent. Blue Cross vigorously defends its own experts. It does not say or imply that if the judge was right to throw out their reports (a possibility it seems to think unthinkable), it is nevertheless entitled to go to trial on the basis of the methodology used and results produced by its opponent's experts. A party can, in resisting summary judgment, rely on his opponent's evidence, theories, or arguments. The question is whether Blue Cross wants to. Apparently it does not; it is represented by sophisticated lawyers who would not keep mum if they thought the Clinic's own method of computing damages gave their client a fair shot at substantial damages. The bottom of the .4 to .9 percent range computes to less than $200,000. Maybe Blue Cross doesn't think this amount is worth further litigation, despite the prospect of trebling. Maybe it doesn't want to have a modest fallback position, but would rather go for broke. Maybe it thinks that to acknowledge any merit in its opponent's experts would fatally undermine the credibility of its own experts, of whom the Clinic's were, naturally, critical. And bear in mind that while we have been treating the defendants' experts' reports as if they were evidence, they are not. They are merely discovery materials. See *Kirk v. Raymark Industries, Inc.*, 61 F.3d 147, 164 (3d Cir.1995); *Bryan v. John Bean Division of FMC Corp.*, 566 F.2d 541, 544-47 (5th Cir. 1978). To get them into evidence, Blue Cross would probably have to subpoena the experts (though conceivably the reports could come into evidence directly under the catch-all exception to the hearsay rule, Fed.R.Evid. 807). It could subpoena these experts, *Kaufman v. Edelstein*, 539 F.2d 811, 821 (2d Cir.1976) (Friendly, J.), but of course they might be reluctant to testify in a way damaging to their client and might be able to squirm out of doing so. Their depositions, as distinct from their reports, do not acknowledge that Blue Cross sustained damages from the division of markets.

All this is speculation; for whatever reason, Blue Cross has waived the right to seek damages on the basis of its opponent's expert reports. And the clincher is what its lawyer told the district judge: that those reports had found "that the market shares of the coconspirators did *not* affect the price charged" (emphasis added). This was a misinterpretation; but by telling the judge not to rely on the defendant's experts for evidence concerning Blue Cross's damages, the plaintiff waived reliance on such evidence should its own evidence fail, as it has done.

So the district judge was right to throw out the damages claim on summary judgment but wrong to throw out the injunction as well and therefore premature in pronouncing the defendant the winner of this lawsuit. The plaintiff has prevailed on a part, although only a small part, of its claim, and this gives it a prima facie entitlement to an award of some of the attorneys' fees and court costs that it incurred. *Ohio-Sealy Mattress Mfg. Co. v. Sealy, Inc.*, 776 F.2d 646, 650-53 (7th Cir.1985); *Sciambra v. Graham News*, 892 F.2d 411, 415 (5th Cir.1990); *Royal Crown Cola Co. v. Coca-Cola Co.*, 887 F.2d 1480, 1485-86 (11th Cir.1989); *United States Football League* *v. National Football League,* 887 F.2d 408, 411-12 (2d Cir.1989); *Home Placement Service, Inc. v. Providence Journal Co., supra,* 819 F.2d at 1209-12. The contrary suggestion in *In re Multidistrict Vehicle Air Pollution,* 481 F.2d 122, 130 n.12 (9th Cir.1973), is not persuasive. For it makes no difference that the only relief that Blue Cross has obtained is equitable; the statute is explicit in allowing an award of attorney's fees when only injunctive relief is sought or awarded. Clayton Act, § 16, 15 U.S.C. § 26; *Home Placement Services, Inc. v. Providence Journal Co., supra,* 819 F.2d at 1210. Blue Cross is not, however, entitled to fees and costs allocable to claims and theories that neither succeeded, nor contributed to the limited victory that it has obtained. *Ohio-Sealy Mattress Mfg. Co. v. Sealy Inc., supra,* 776 F.2d at 652-53; *H.J. Inc. v. Flygt Corp.,* 925 F.2d 257, 260-61 (8th Cir.1991); see also *Reazin v. Blue Cross & Blue Shield of Kansas,* 899 F.2d 951, 980 (10th Cir.1990). That would be unreasonable, and the Clayton Act entitles a prevailing plaintiff only to "a reasonable attorney's fee." Clayton Act, §§ 4, 16, 15 U.S.C. §§ 15(a), 26; cf. *Hensley v. Eckerhart,* 461 U.S. 424, 103 S.Ct. 1933, 76 L.Ed.2d 40 (1983).

We vacate the district court's decision relating to attorneys' fees and to costs, as well as its denial of injunctive relief, but we affirm the denial of damages, and we remand the case to the district court for further proceedings consistent with this opinion.

AFFIRMED IN PART, VACATED IN PART, AND REMANDED.

APPENDIX B

UNITED STATES COURT OF APPEALS
SEVENTH CIRCUIT

Nos. 95-1965, 95-2140

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN and
COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Plaintiffs-Appellees,
Cross-Appellants,

v.

MARSHFIELD CLINIC and SECURITY HEALTH
PLAN OF WISCONSIN, INC.,
Defendants-Appellants,
Cross-Appellees.

Argued Aug. 9, 1995
Decided Sept. 18, 1995

As Amended on Denial of Rehearing
Oct. 13, 1995

Before POSNER, Chief Judge, and BAUER and KANNE, Circuit Judges.

POSNER, Chief Judge.

Blue Cross & Blue Shield United of Wisconsin ("Blue Cross" for short), and its subsidiary, Compcare Health Services Insurance Corporation, a health maintenance organization (HMO), brought suit last year under sections

1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2, against the Marshfield Clinic and its HMO subsidiary, Security Health Plan of Wisconsin, Inc. After a two-week trial, the jury brought in a verdict for both plaintiffs that, after remittitur, trebling, and addition of attorneys' fees, produced a judgment just short of $20 million to which the judge then added a sweeping injunction that we have stayed pending the decision of the defendants' appeal, which we have heard on an expedited schedule. (The plaintiffs filed a cross-appeal, but it was dismissed by agreement of the parties.) The speed with which this complex case was brought to trial is as commendable as it is unusual.

The two plaintiffs have distinct though overlapping claims. Compcare, Blue Cross's HMO, claims that the Marshfield Clinic—a nonprofit corporation owned by the 400 physicians whom it employs—has a monopoly which it acquired and has maintained by improper practices that have excluded Compcare from the HMO "market" in the counties of north central Wisconsin in which the Marshfield Clinic and its HMO subsidiary (Security) operate. This is a section 2 monopolization charge. Blue Cross claims that Marshfield, partly through its own monopoly power and partly by collusion with other providers of medical services, charged supra-competitive prices to patients insured by Blue Cross. This is a section 2 monopolization charge combined with a section 1 price-fixing and division-of-markets charge.

Although Marshfield is a town of only 20,000 people in a largely rural region, the Marshfield Clinic is the fifth largest physician-owned clinic in North America, with annual revenues in excess of $200 million. The Clinic has its main office in Marshfield but it has 21 branch offices scattered throughout the 14 counties of north central Wisconsin. Oddly, we cannot find in the record, nor were counsel able to inform us at argument, what percentage the 400 physicians employed by the Clinic comprise of all the physicians in the 14 counties. We do know that the Clinic employs all the physicians in Marshfield itself and in several other towns—but one of these towns has only one physician—and all the physicians in one entire county—but a county that has only 12 physicians. Security, the Marshfield Clinic's HMO subsidiary, serves its subscribers through the physicians employed by the Clinic plus almost 900 other physicians with whom Security has contracts. These contracts are not exclusive—the physicians are free to work for other HMOs as well as to practice fee-for-service medicine—and in fact work for Security generates only 6 percent of these physicians' total income. (Compcare argues that the 6 percent figure is found only in a study and testimony excluded from evidence, but our reading of the objection to the testimony and the ruling on that objection is that not the figure, but only the witness's effort to characterize it as insignificant, was excluded.) In nine of the 14 counties in the north central region, Security has more than 90 percent of all subscribers to HMOs.

Compcare persuaded the jury that HMOs constitute a separate market, much as banks are a separate market from currency exchanges; and if there is a reasonable basis for this finding in the evidence, we are bound to accept it regardless of what we might think as an original matter. But we have searched the record in vain for evidence that under contemporary principles of antitrust law would justify such a finding. An HMO is not a distinctive organizational form or assemblage of skills, as is plain from the fact that the physicians retained by Security, whether they are employees of the Marshfield Clinic or completely independent, to serve its subscribers serve other patients on a fee-for-service basis. An HMO is basically a method of pricing medical services. Instead of having the patient pay separately for each medical procedure, the patient pays a fixed annual fee for all the services he needs and the HMO undertakes to provide those services with the physicians with whom it has contracts. The different method of pricing used by the HMO has, of course, consequences both for the practice of medicine and for the allocation of the risk of medical expenses. The method of pricing gives the HMO an incentive to minimize the procedures that it performs, since the marginal revenue it derives from each procedure is zero. Hence HMOs are thought to reduce "waste" and to encourage preventive care, although those hostile to the HMO concept believe that the principal effect is merely to reduce the amount of medical care that patients receive. The risk-shifting feature of the concept lies in the fact that if a subscriber incurs above-average medical expenses, the excess cost is borne by the HMO rather than by the subscriber (or by his insurer, or more likely by both because of copayment and deductible provisions in the insurance policy), while if he incurs below-average medical expense the difference enures to the benefit of the HMO rather than to him or his insurer (or, again, both). To control the upside risk that it incurs, the HMO provides medical services through physicians with whom it has contracts specifying their compensation, rather than merely reimbursing some percentage of whatever fee they might happen to charge for their services. This means that the HMO must be able to line up enough physicians with whom to contract to provide its subscribers with a more or less complete menu of medical services. Compcare complains that Security's contracts with physicians require them to refer their patients to the Clinic rather than to "independent" physicians. But that is of the essence of an HMO: the subscriber must take the service offered by the physicians whom the HMO has enlisted.

Compcare's principal argument is that Security has enlisted such a large fraction of the physicians in the 14-county north central region that Compcare cannot find enough "independent" physicians to be able to offer HMO services competitive with Security's—hence Security's huge market shares in 9 of the 14 counties. Supposing this is true—as seems unlikely since Security's almost 900 independent physicians are available to join other HMOs, along with an unknown number of physicians neither employed by the Marshfield Clinic nor retained by Security—it has monopolistic significance only if HMOs constitute a market separate from other contractual forms in which many of the same physicians sell their services. Of this we cannot find any evidence.

In defining a market, one must consider substitution both by buyers and by sellers, IIA Phillip E. Areeda, John L. Solow & Herbert Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* ¶ 530a (1995), and let us start with buyers. The record shows, what is anyway well known, that individuals, and their employers, and medical insurers (the real "buyers" of medical services, according to the plaintiffs) regard HMOs as competitive not only with each other but also with the various types of fee-for-service provider, including "preferred provider" plans (generally referred to as "PPOs," for "preferred provider organization") under which the insurer offers more generous reimbursement if the insured patronizes physicians who have contracts with the insurer to provide service at low cost to its insureds. HMOs, though they have made great strides in recent years because of the widespread concern with skyrocketing medical costs, remain relative upstarts in the market for physician services. Many people don't like them because of the restriction on the patient's choice of doctors or because they fear that HMOs skimp on service, since, as we said, the marginal revenue of a medical procedure to an HMO is zero. From a short-term financial standpoint—which we do not suggest is the only standpoint that an HMO is likely to have—the HMO's incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible. HMOs compensate for these perceived drawbacks by charging a lower price than fee-for-service plans.

We do not wish to associate ourselves with the critics of HMOs. All that is important to our consideration of this appeal is that many people believe—whether rightly or wrongly is of no moment—that HMOs are not an unalloyed blessing; and this means that the price that an HMO can charge is constrained not only by competition from other HMOs but also by competition from forms of medical-services contracting that are free from the perceived perverse incentive effects of the HMO form. As far as we know or the record shows, even in areas where there is only one HMO most of the people in its service area do not subscribe to it even if its prices are lower than those of fee-for-service providers.

We do not understand Compcare to be contending that insurance companies cannot find enough physicians in the north central region willing to sign contracts with them to staff preferred-provider plans. This has a dual significance. Such plans are particularly close substitutes for HMOs, since they use the insurer's clout with physicians to drive down price. And if, as the record shows, they are feasible even in areas supposedly dominated by the Marshfield Clinic, and even without including any physicians employed by the Clinic, it is impossible to understand what barrier there could be to the formation of HMOs. All that is needed is an array of physicians who among them provide a broad range of medical services, and the same thing is needed for a preferred-provider plan. Ability to create a preferred-provider plan therefore implies ability to create an HMO, and so implies in turn that if Security raised its prices above competitive levels, and if people had a strong preference for HMOs over preferred-provider plans despite the similarities between the two systems for providing medical care, the operators of those plans would convert them to HMOs. If so, those plans are part of the same market with HMOs. So Blue Cross and Blue Shield of Indiana argued in *Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc.*, 784 F.2d

1325 (7th Cir.1986), and we accepted its argument. *Id.* at 1331-37.

As we said earlier, the definition of a market depends on substitutability on the supply side as well as on the demand side. Even if two products are completely different from the consumer's standpoint, if they are made by the same producers an increase in the price of one that is not cost-justified will induce producers to shift production from the other product to this one in order to increase their profits by selling at a supracompetitive price. *SBC Communications Inc. v. FCC,* 56 F.3d 1484, 1493-94 (D.C.Cir.1995); cf. *Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc., supra,* 784 F.2d at 1335. The services offered by HMOs and by various fee-for-service plans are both provided by the same physicians, who can easily shift from one type of service to another if a change in relative prices makes one type more lucrative than others.

We thus do not believe that a reasonable jury, confronting the record compiled in the district court, could find that HMOs constitute a separate market. (We emphasize "record compiled in the district court." Terms such as "HMO" and "PPO" are used to refer to a variety of different types of plan, which may vary in respects crucial to antitrust liability.) Nor, if we examine a more plausible market such as all physician services in north central Wisconsin and thus shift our focus from Security, the HMO, to the Marshfield Clinic itself, is there any basis in the record for treating the Clinic not as the alliance of 400 physicians that is the Marshfield Clinic but instead as the almost 1300 physicians who are either employed by the Clinic or have contracts with Security. The 900 independent contractors derive only a small fraction of their income from those contracts, as we have seen, and the contracts do not forbid them to join other HMOs or otherwise compete with Security or with the Marshfield Clinic.

It is true that because of the sparsity of the physician population in north central Wisconsin the physicians employed by the Clinic have a large share of the market for physician services, since, for primary care anyway (an important qualification—people will go a long way for a liver transplant), that market is a local one. Remember, there is one entire county in which all the physicians are employed by the Clinic. We do not understand Compcare to be arguing that *this* is the market that the Clinic monopolized; the damages to Compcare from being excluded (if it was excluded—we do not know) from that tiny market would be tiny. Compcare paints with a broader brush, drawing a dizzying series of concentric circles around the Clinic's offices and counting the physicians who can serve people living in the circles. It would have been much simpler and we suppose just as good—having in mind the desirability of avoiding a hunt for the snark of delusive exactness—to have treated the counties as the markets. But whatever the precise method chosen, Compcare is unable to show that in what it chooses to regard as the relevant geographic market or series of linked geographic markets for physician services the Marshfield Clinic employed 50 percent or more of the physicians serving the market. Fifty percent is below any accepted benchmark for inferring monopoly power from market share, *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1285 (7th Cir.1990); *Fineman v. Armstrong World Industries, Inc.*, 980 F.2d 171, 201-02 (3d Cir.1992); *Colorado Interstate Gas Co. v. Natural Gas Pipeline Co.*, 885 F.2d 683, 694 n. 18 (10th Cir. 1989); *United States v. Aluminum Co. of America*, 148 F.2d 416, 424 (2d Cir.1945) (L. Hand, J.), and the Clinic has given us no reason for lowering the mark. Compcare is able to derive larger shares only by defining submarkets of specific, very narrowly defined medical procedures, called "Diagnostic Related Groups," such as circumcision of a male 17 years old or older, circumcision of a male under 17, hysterectomy, and reconstructive surgery for the uterine system, in a few of which (14 out of 494, according to Compcare's expert witness) the physicians employed by or under contract with the Marshfield Clinic performed most of the procedures in north central Wisconsin. As the examples we have given show, classification in a DRG is unrelated to the conditions of supply. Many, no doubt most, physicians perform or are capable of performing more than one procedure, and are therefore part of the market even if at present not active in it. If Clinic overprices a particular procedure, other physicians capable of performing that procedure will have an added incentive to do so, knocking down the excessive price.

Compcare also asked the jury to infer monopoly power directly from the Clinic's high prices, and high rate of return, relative to the prices and rates of return of its competitors. But when dealing with a heterogeneous product or service, such as the full range of medical care, a reasonable finder of fact cannot infer monopoly power just from higher prices—the difference may reflect a higher quality more costly to provide—and it is always treacherous to try to infer monopoly power from a high rate of return. Taking the second point first, not only do measured rates of return reflect accounting conventions more than they do real profits (or losses), as an economist would understand these terms, Susan Rose-Ackerman, "Unfair Competition and Corporate Income Taxation, 34 *Stan.L.Rev*. 1017, 1025 n.28, 1031 n.43 (1982); Michael Boudin, "Forensic Economics," 97 *Harv.L.Rev*. 835, 837 (1984), but there is not even a good economic theory that associates monopoly power with a high rate of return. Firms compete to become and to remain monopolists, and the process of competition erodes their profits. Conversely, competitive firms may be highly profitable merely by virtue of having low costs as a result of superior efficiency, yet not sufficiently lower costs than all other competitors to enable the firm to take over its market and become a monopolist. As for high prices, one of the complaints against HMOs, remember, is that they skimp on service. One HMO may charge higher prices than other HMOs (and Security does charge higher prices) not because it has a monopoly but because it is offering better service than the other HMOs in its market. Compcare itself stresses the quality of the Marshfield Clinic's doctors, as part of its argument that it cannot succeed unless the Clinic is forced to join it. Generally you must pay more for higher quality.

So Security is not a monopolist of HMO services, because, subject to our earlier qualification, HMO's are not a market. The Marshfield Clinic, its parent, is not a monopolist either. It does not control its independent contractors; and once they are excluded, the Clinic (which is to say the physicians who own and are employed by it —who are the firm, functionally speaking) does not have a monopoly of physician services in the north central region or in any parts of the region other than parts too small to support more than a handful of physicians. If the Marshfield Clinic is a monopolist in any of these areas it is what is called a "natural monopolist," which is to say a firm that has no competitors simply because the market is too small to support more than a single firm. If an entire county has only 12 physicians, one can hardly expect or want them to set up in competition with each other. We live in the age of technology and specialization in medical services. Physicians practice in groups, in alliances, in networks, utilizing expensive equipment and support. Twelve physicians competing in a county would be competing to provide horse-and-buggy medicine. Only as part of a large and sophisticated medical enterprise such as the Marshfield Clinic can they practice modern medicine in rural Wisconsin.

We are mindful that a concept of essential or bottleneck facilities has been used from time to time to require a natural monopolist to cooperate with would-be competitors. E.g., *Otter Tail Power Co. v. United States,* 410

U.S. 366 (1973); *MCI Communications Corp. v. AT & T Corp.*, 708 F.2d 1081, 1132-33 (7th Cir.1983). The principal case remains the old St. Louis terminal case. *United States v. Terminal Railroad Ass'n*, 224 U.S. 383, 32 S.Ct. 507, 56 L.Ed. 810 (1912). A consortium of 14 of the 24 railroads that shipped freight across the Mississippi River at St. Louis got control of the terminal facilities at each side of the river. The Supreme Court, while assuming that the operation of these facilities as a single entity was the most efficient way to operate them (that is, they comprised a natural monopoly), held that the Sherman Act required the consortium to provide access to the terminal facilities to the 10 other railroads on nondiscriminatory terms. The decision, along with the rest of the decisions in the essential-facilities line, has been criticized as having nothing to do with the purposes of antitrust law. E.g., Herbert Hovenkamp, *Federal Antitrust Policy: The Law of Competition and Its Practice* § 7.7 (1994); Phillip Areeda, "Essential Facilities: An Epithet in Need of Limiting Principles," 58 *Antitrust L.J.* 841 (1990); Scott D. Makar, "The Essential Facilities Doctrine and the Health Care Industry," 21 *Fla.St.U.L.Rev.* 913 (1994). Had the terminal facilities been owned by a firm unaffiliated with any railroad, the firm could have charged whatever prices it wanted, including prices that discriminated against some of the users (monopolists frequently price discriminate), because the antitrust laws do not regulate the prices of natural monopolists. A natural monopolist that acquired and maintained its monopoly without excluding competitors by improper means is not guilty of "monopolizing" in violation of the Sherman Act, *National Reporting Co. v. Alderson Reporting Co.*, 763 F.2d 1020, 1023-24 (8th Cir.1985); *United States v. Aluminum Co. of America, supra,* 148 F.2d at 430, and can therefore charge any price that it wants, *Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc., supra,* 784 F.2d at 1339; *Berkey Photo, Inc. v. Eastman Kodak*

Co., 603 F.2d 263, 296-98 (2d Cir.1979), for the antitrust laws are not a price-control statute or a public-utility or common-carrier rate-regulation statute.

And the charging of a high price is, so far as potential competitors are concerned, an attracting rather than an excluding practice. Consumers are not better off if the nautral monopolist is forced to share some of his profits with potential competitors, as required by *Terminal Railroad Ass'n.* Similarly, if the practice of medicine in some sparsely populated county of north central Wisconsin is a natural monopoly, consumers will not be helped by our forcing the handful of physicians there to affiliate with multiple HMOs. Those physicians will still charge fees reflecting their monopoly.

We are not authorized to abrogate doctrines that have been endorsed and not yet rejected by the Supreme Court —as we acknowledged, indeed emphasized, with specific reference to the "essential facilities" doctrine, in *Olympia Equipment Leasing Co. v. Western Union Telegraph Co.*, 797 F.2d 370, 376 (7th Cir.1986)—but we do not understand Compcare to be trying to pin the tail on the natural-monopoly donkey. Its argument is not that the Marshfield Clinic "owns" some tiny natural monopolies scattered throughout it market area, to which it must admit Compcare, but that the Clinic itself is an essential facility that any HMO may demand access to on equal terms, like the excluded railroads in the terminal case. To be an essential facility, however, a facility must be essential. The terminal association controlled 100 percent of a market, assumed to be properly defined, consisting of terminal services at St. Louis. The Clinic does not control 100 percent—or even 50 percent—of any properly defined market. It did have a monopoly market share of the HMO "market," but we have held that that is not a proper market; and likewise the DRGs. Nor can the Clinic's market share be levered up to 100 percent by the argument that the Clinic's reputation is so superb that no one will sign up with an HMO or preferred-provider plan that does not have the Clinic on its roster. The suggestion that the price of being "best" is to be brought under the regulatory aegis of antitrust law and stripped of your power to decide whom to do business with does not identify an interest that the antitrust laws protect. "The successful competitor, having been urged to compete, must not be turned upon when he wins." *United States v. Aluminum Co. of America, supra,* 148 F.2d at 430.

Since monopoly power was not proved, we need not evaluate the practices by which the Clinic acquired or maintained it. But we will not conceal our skepticism that they are exclusionary in an invidious sense. Compcare argues that the Clinic refused to allow its employees to "cross-cover" with "independent" physicians, in the sense of physicians not employed by or affiliated by contract with the Clinic (that is, agree to care for another physician's patients when that physician is on vacation or otherwise unavailable in exchange for a reciprocal agreement by the other physician), discouraged hospitals that its staff controlled from joining HMOs that compete with Security, and restricted staff privileges at those hospitals of "independent" physicians at those hospitals. All these practices are ambiguous from the standpoint of competition and efficiency. Hospitals are not public utilities, required to grant staff privileges to anyone with a medical license. The Marshfield Clinic's reputation for high quality implies selectivity in the granting of staff privileges at hospitals affiliated with the Clinic. Physicians employed by the Clinic, which has its own HMO, are hardly to be expected to steer their patient to another HMO, as they would be doing if they used their control of hospital staffs to induce the hospital to join another HMO. And given the extensive network constituted by the physicians either employed by or contracting with the Clinic, they would have little occasion to "cross-cover" with other physicians and would be reluctant to do so if, as is completely consistent with Compcare's version of the "essential facilities" doctrine, the Clinic maintains a reputation for high quality by being selective about the physicians to whom it entrusts its customers. But the important point is that, even if these practices are as we doubt tortious interferences with Compcare's business, they do not constitute monopolizing in violation of section 2 of the Sherman Act in the absence of acceptable proof, here lacking, of monopoly power.

We turn to Blue Cross's case. Blue Cross claims that it was overcharged by the Clinic. Many of the individuals whom Blue Cross insures in north central Wisconsin are customers of the Marshfield Clinic, paying for the services they receive from the Clinic on a fee-for-service basis. (The Clinic's doctors devote only a small part of their time to Security's HMO clientele.) Blue Cross pays the Clinic directly the portion of the fee that Blue Cross has agreed with its insureds to cover. The Clinic seeks to head off Blue Cross's claim at the pass, arguing that since the Clinic's fee-for-service contracts are with the patients themselves—it has no contract with Blue Cross—only the patients have "standing" (a term here not used in the jurisdictional sense, *Associated General Contractors of California, Inc. v. California State Council of Carpenters,* 459 U.S. 519, 535 n.31, 103 S.Ct. 897, 907 n.31, 74 L.Ed.2d 723 (1983)) to complain about the alleged overcharging.

If the patients paid the entire fees to the Clinic and then were reimbursed in whole or part by Blue Cross, the Clinic would be right: only the patients could sue. The Supreme Court has been emphatic that only the direct purchaser from an allegedly over-charging defendant has standing to maintain an antitrust suit. *Kansas v. Utilicorp United Inc.,* 497 U.S. 199, 110 S.Ct. 2807, 111 L.Ed.2d 169 (1990); *Illinois Brick Co. v. Illinois,* 431 U.S. 720, 97 S.Ct. 2061, 52 L.Ed.2d 707 (1977). But here the money went directly from Blue Cross to the Clinic, and although the two entities were not linked by any overarching contract, each payment and acceptance was a separate completed contract. We do not think more is required to establish Blue Cross's right to sue to collect these overcharges. *Pennsylvania Dental Ass'n v. Medical Service Ass'n,* 815 F.2d 270, 276-77 (3d Cir.1987); *Todorov v. DCH Healthcare Authority,* 921 F.2d 1438, 1445 (11th Cir.1991); cf. *Kartell v. Blue Shield of Mass., Inc.,* 749 F.2d 922, 926 (1st Cir.1984). It would be cumbersome, to say the least, for patients of the Marshfield Clinic to organize into a class action to recover money that the patients never paid and that if they received in a judgment or settlement they would have to share with Blue Cross; for Blue Cross could seek and probably obtain restitution of moneys paid by mistake to the insureds because paid for expenses that the insureds had not in the end incurred. 2 George E. Palmer, *The Law of Restitution* § 11.2(d), p. 491 (1978); *Home Ins. Co. v. Honaker,* 480 A.2d 652 (Del.1984); *Ticor Title Ins. Co. v. Graham,* 576 N.E.2d 1322, 1336-37 (Ind.App.1991).

Against this it can be argued that if Blue Cross reimburses an insured for say 80 percent of a $100 charge that should have been only $50, Blue Cross has lost $40 but the insured has lost $10 and so there is still a basis for a class action. Still, in this example anyway it is Blue Cross that bears the lion's share of the loss, as well as being able to proceed on its own without the aggregation of separate plaintiffs required for a class action; and the class action would enable a full recovery of the damages inflicted by the defendant only if the class members received a tremendous windfall—only, that is, if the class is allowed to recover $40 rather than $10 (and the entire $50 will of course be trebled). It can further be argued that the insured might pay the whole $50, because Blue Cross would reduce the percentage that it reimburses in order to shift the cost of the monopolists's overcharge to the hapless insureds. But the insureds may not be hapless —may in fact be members of the employees' group insurance plan of a large employer with plenty of insurance options. We need not pursue these issues. Blue Cross paid Marshfield Clinic directly, in accordance with Blue Cross's contractual obligations to its insureds, and if it paid too much because the Clinic violated the antitrust laws then it ought to be allowed to sue to recover these damages.

We note a tension between Blue Cross's claim and Compcare's. Blue Cross claims that the Clinic overcharged. The higher its prices, the greater the opening for competitors, such as Compcare. Even if Compcare could not get a foothold in the HMO "market," it could, of course, provide medical services through other means, such as a preferred-provider plan; and the higher the prices charged by the Marshfield Clinic, the more attractive such a plan offered by Compcare would be to employers and other purchasers of medical plans. To put the point differently, Blue Cross has a dual role in this case, as a buyer of medical services from Marshfield Clinic and, through its Compcare subsidiary, as a competitor of the Clinic. As a competitor its interest is in the Clinic's charging high prices, but as a buyer its interest is in the Clinic's charging low prices. Damages to Compcare are windfalls to Blue Cross, and vice versa. The damages awarded by the jury to the two plaintiffs (since they are economically one entity) should have been netted against each other rather than aggregated.

But that is a detail, since Compcare, for the reasons discussed earlier, was not entitled to recover any damages at all. Forget Compcare, then, and think of Blue Cross solely as a purchaser of medical services. Insofar as it paid high prices because the Marshfield Clinic was a monopolist, its claim must fail because the Clinic was not shown to be an illegal monopolist; a lawful monopolist can charge what it wants. But Blue Cross also claims that the Clinic colluded with competitors to raise prices above competitive levels. That claim is independent of the Clinic's being a monopolist.

Two forms of collusion are charged, with various furbelows and arabesques that can be ignored. The first is collusion between the Clinic and its affiliated (as distinct from employed) physicians. Here the tension between the two plaintiffs' cases again comes to the surface, since it will be recalled that Compcare in its case treats the affiliated physicians as a part of the Clinic, and a firm cannot collude with itself. Forget all that; the only evidence of collusion is that the Clinic, when buying services from the affiliated physicians either directly or through Security, would not pay them more than what these physicians charge their other patients. This is said to put a floor underneath these physicians' prices, since if they cut prices to their other patients their reimbursement from the Clinic will decline automatically. This is an ingenious but perverse argument. "Most favored nations" clauses are standard devices by which buyers try to bargain for low prices, by getting the seller to agree to treat them as favorably as any of their other customers. The Clinic did this to minimize the cost of these physicians to it, and that is the sort of conduct that the antitrust laws seek to encourage. It is not price-fixing. *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, —— U.S. ——, ——, 113 S.Ct. 2578, 2589-90, 125 L.Ed.2d 168 (1993); *Hospital Corp. of America v. FTC*, 807 F.2d 1381, 1392 (7th Cir.1986); *Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc., supra,* 784 F.2d at 1388. Perhaps, as the Department of Justice believes, these clauses are misused to anticompetitive ends in some cases; but there is no evidence of that in this case.

The other form of collusion alleged is more troublesome. The Clinic is said to have agreed with some of its competitors, in particular the North Central Health Protection Plan, an HMO that had 37,000 subscribers, to divide markets, a practice that violates section 1 of the Sherman Act. *Palmer v. BRG of Georgia, Inc.*, 498 U.S. 46, 111 S.Ct. 401, 112 L.Ed.2d 349 (1990) (per curiam). This analogy between price-fixing and division of markets is compelling. It would be a strange interpretation of antitrust law that forbade competitors to agree on what price to charge, thus eliminating price competition among them, but allowed them to divide markets, thus eliminating all competition among them.

The charge of a division of markets in this case is backed up by some pretty strong documents. In one of them an executive of the Marshfield Clinic, after noting that "at the time in which management of Marshfield Clinic and North Central Health Protection Plan established the Free Flow arrangements, the parties involved purposely chose not to place in writing clear descriptions of their respective Plan service areas so as to minimize any risk in terms of violation of antitrust laws," remarks that some years ago physicians affiliated with the NCHPP "wished to establish a practice in Marshfield and we took the position that the Free Flow agreement did not support that activity"—and they backed off. The implications of this only slightly Aesopian wording are backed up by statistics showing that Security had fewer than 30 percent of the HMO subscribers in the two counties in which NCHPP was active, while in the counties surrounding those two counties on three sides it had more than 90 percent of the HMO subscribers.

We think the evidence of a division of markets, though a little scanty, was sufficient to sustain the jury's verdict on this (and only this) aspect of the case—provided this is not one of those cases in which a division of markets or other cartel-like activity is actually essential to the provision of a lawful service. *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 99 S.Ct.

1551, 60 L.Ed.2d 1 (1979); *National Collegiate Athletic Ass'n v. Board of Regents,* 468 U.S. 85, 104 S.Ct. 2948, 82 L.Ed.2d 70 (1984); *General Leaseways, Inc. v. National Truck Leasing Ass'n,* 744 F.2d 588 (7th Cir. 1984). The "Free Flow" agreement to which the document from which we quoted refers was an agreement whereby Security's physicians and NCHPP's physicians could refer patients to each other without getting the permission of their superiors. The plan of the physician who rendered the service would bill the other plan for its cost. This was no doubt a valuable service, expanding the range of physicians to whom people enrolled in these two HMOs could turn. But the Clinic has failed to explain why, to provide this service, it was necessary for the two plans to agree not to open offices in each other's territories. We can imagine an argument that would run as follows: if NCHPP, say, opened an office in Marshfield, the doctors staffing that office would constantly be referring patients to the Clinic because it has such a plethora of doctors in Marshfield (remember that it employs *all* the doctors working in that town). The office would be running a referral business, "free riding" on the reputation and quality of Marshfield's doctors, and perhaps it would be difficult to devise a reimbursement plan under which these doctors would be compensated for these services. It is not a bad argument, but it is not made by the Clinic and it has no support in the record.

We conclude that the jury verdict on liability must stand insofar as the charge of a division of markets is concerned, and therefore the provisions of the injunction (IV(A)(3), (B)(3), (C)(3), (D)(3), and (E)(2), and V(D)(1)—and possibly others; but for the sake of clarity and completeness the injunction ought to be rewritten from scratch in light of our invalidating most of it) that forbid the Clinic to divide markets with competing plans or groups. The rest of the injunction falls with the charges that we have held to be without legal or factual basis. No part of the award of damages or of costs and attorneys' fees can stand, because these items were not segregated by offense. There must be a new trial limited to damages for dividing markets. The burden will be on Blue Cross to show how much less it would have paid the Clinic had the Clinic refrained from that illegal practice.

We have not discussed every contention of the parties, but have said enough to indicate the basis for our decision. As a detail, we urge the bench and bar of this circuit not to imitate the special verdict on liability that went to the jury in this case. The verdict form contained 18 questions. If the jury wanted to find for the plaintiff on every contested point, all it had to do (and all it did do) was write "yes" 18 times. A verdict so configured, like a plea colloquy in which the answer that the defendant is expected to give to every one of the judge's questions is "yes," *Castillo v. United States,* 34 F.3d 443, 445 (7th Cir. 1994), invites rote answers rather than the careful consideration of the structure of the plaintiff's case that the use of a special verdict is intended to foster. Cf. *W.T. Rogers Co. v. Keene,* 778 F.2d 334, 346 (7th Cir. 1985). None of the purposes ascribed to the giving of a special verdict, *Stewart & Stevenson Services, Inc. v. Pickard,* 749 F.2d 635, 644 (11th Cir.1984); 9A Charles Alan Wright & Arthur R. Miller, *Federal Practice and Procedure* § 2508 (1995), of which probably the most important is to minimize the likelihood or scope of a retrial in a case in which there is more than one independent ground for recovery, are served by a verdict form that does not invite the jurors to use their heads. Given the broad discretion of the trial judge in the formulation of special verdicts, e.g., *Hibma v. Odegaard,* 769 F.2d 1147, 1157 (7th Cir.1985), and the fact that no objection was made to the form employed here, we do not suggest that this form would have constituted reversible error if the point had been argued; we merely offer for what it is worth our belief that it is not the best possible form, because it does not force the jurors to think before filling it out.

The judgment is affirmed in part, reversed in part, and remanded for further proceedings consistent with this opinion. Costs on appeal to the appellants.

AFFIRMED IN PART, REVERSED IN PART, AND REMANDED.

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

Nos. 95-1965, 95-2140

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN and
COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Plaintiffs-Appellees,
Cross-Appellants,

v.

MARSHFIELD CLINIC and
SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Defendant-Appellants,
Cross-Appellees.

October 13, 1995, Decided

Appeals from the United States District Court
for the Western District of Wisconsin
No. 94 C 137 S—John C. Shabaz, Judge

Before Hon. Richard A. Posner, Chief Judge, Hon. William J. Bauer, Circuit Judge, Hon. Michael S. Kanne, Circuit Judge.

ORDER

Upon consideration of the petition for rehearing and the brief of the United States and the Federal Trade Commission in support of the petition, the slip opinion in this matter, issued on September 18, is amended as follows:

P. 3, after first full sentence, beginning "These contracts are not exclusive . . .": the following sentence is inserted: "(Compcare argues that the 6 percent figure is found only in a study and testimony excluded from evidence, but our reading of the objection to the testimony and the ruling on that objection is that not the figure, but only the witness's effort to characterize it as insignificant, was excluded."

P. 6, after last full sentence on page, ending "a separate market.": the following sentence is inserted: "(We emphasize "record compiled in the district court." Terms such as "HMO" and "PPO" are used to refer [*2] to a variety of different types of plan, which may very in respects crucial to antitrust liability.)"

P. 9, first sentence after paragraph break: "because HMOs are not a market" is changed to "because, subject to our earlier qualification, HMOs are not a market."

P. 16, before paragraph break: at end of preceding paragraph (ending "1338") the following new sentence is inserted: "Perhaps, as the Department of Justice believes, these clauses are misused to anticompetitive ends in some cases; but there is no evidence of that in this case."

Save for these amendments to the slip opinion, the petition for rehearing is DENIED.

APPENDIX D

[Filed Sep. 10, 1996]

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF WISCONSIN

94-C-0137-C

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN, and
COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Plaintiffs,
v.

THE MARSHFIELD CLINIC and
SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Defendants.

OPINION AND ORDER NO. 1

This antitrust suit is before the court following remand from the Court of Appeals for the Seventh Circuit. Plaintiffs Blue Cross & Blue Shield United of Wisconsin (Blue Cross) and its subsidiary, a health maintenance organization known as Compcare Health Services Insurance Corporation, sued defendants Marshfield Clinic and Security Health Plan of Wisconsin, Inc., charging that defendants had violated the Sherman Antitrust Act by dividing markets and fixing prices in violation of 15 U.S.C. § 1 and by monopolizing the delivery of medical services in a manner that has excluded Compcare from the health maintenance market in certain counties of north-central Wisconsin, in violation of 15 U.S.C. § 2. After a two week trial before the Honorable John C. Shabaz, a jury found in plaintiffs' favor and awarded damages of approximately $20 million before trebling. Judge Shabaz found the award "monstrously excessive" and offered plaintiffs a choice between a new trial or a remittitur of approximately $5.5 million (reducing Blue Cross's award to $594,883 and Compcare's to $5,074,394), to be trebled by the court. *Blue Cross v. Marshfield Clinic,* 883 F. Supp. 1247, 1262 (W.D. Wis. 1995). In addition, Judge Shabaz enjoined defendants from engaging in any further antitrust activity. *Id.* at 1268-70. Plaintiffs accepted the remittitur and defendants appealed the judgment.

The court of appeals struck down all but one of plaintiffs' antitrust theories and vacated most of the injunction. It upheld the jury's verdict only on plaintiffs' claim that defendants had divided markets with competing health providers. *Blue Cross & Blue Shield v. Marshfield Clinic,* 65 F.3d 1406, 1416 (7th Cir. 1995), *cert. denied,* 116 S. Ct. 1288 (1996). The court let stand those portions of the injunction that prohibited defendants from entering into agreements to divide markets, but suggested that the injunction would have to be rewritten in light of the disposition of the other claims. As to damages, the court held that:

> No part of the award of damages or of costs and attorneys' fees can stand, because these items were not segregated by offense. There must be a new trial limited to damages for dividing markets. The burden will be on Blue Cross to show how much less it would have paid the Clinic had the Clinic refrained from that illegal practice.

Id.

Pursuant to Circuit Rule 36, the case was reassigned on remand. It is presently before the court on plaintiff's motion to define the scope of the court of appeals' remand order. The issues in contention are 1) whether Compcare Health Services Insurance Corporation is still a party to the suit; 2) whether it is the law of the case that plaintiffs have proven an illegal division of markets with respect to Rhinelander Medical Center, the Wausau, area, the Ministry hospitals and the North Central Health

Protection Plan or whether plaintiffs are limited to recovering damages only with respect to North Central; 3) whether Blue Cross has to prove that any injury it incurred was caused by the illegal market division; 4) whether the remittitur limits Blue Cross's potential damage award on remand to a maximum of $594,883; and 5) whether the court of appeals overruled by implication Judge Shabaz's decision that plaintiffs could not recover damages under Wis. Stat. § 133.14.

A. *Compcare's Entitlement to Damages*

The court of appeals found that Blue Cross and Compcare had distinct but overlapping claims. *Blue Cross & Blue Shield,* 65 F.3d at 1408. Compcare contended that Marshfield Clinic had a monopoly it acquired and maintained by improper practices that excluded Compcare from the health maintenance organization (HMO) market in north-central Wisconsin and that this monopoly violated Section 2 of the Sherman Antitrust Act. *Id.* Blue Cross sued under both Section 2 (monopoly) and Section 1 (price-fixing and division of markets), contending that Marshfield Clinic had used its monopoly power and collusion with other providers of health services to charge supra-competitive prices to patients insured by Blue Cross. *Id.* The court of appeals held that HMOs do not constitute a separate market for antitrust purposes, *id.* at 1409, and for this reason, dismissed Compcare's and Blue Cross's Section 2 monopoly claims for lack of evidence. *Id.* at 1414. The court concluded that because Compcare had not pursued a Section 1 claim, it "was not entitled to recover any damages at all." *Id.* at 1415.

Plaintiffs argue that the appellate decision reopened the whole question of damages as they relate to market division and that because there has been no "final" judgment on damages, Compcare is entitled to prove damages from market division because it was a purchaser of health services. Plaintiffs contend that Compcare is not barred entirely from recovering any damages; it is barred only from recovering damages under Section 2. Although plaintiffs admit that the court referred specifically to Blue Cross in its remand order, they argue that this should be read as inclusionary, not exclusionary, and that the omission of any mention of Compcare does not mean the court of appeals intended to exclude the subsidiary. Furthermore, plaintiffs argue, Compcare should be allowed to prove damages from defendants' illegal division of markets for two reasons: (1) it suffered lost profits because the division of markets also included an agreement by the physicians to sign up with only one HMO in the general region; and (2) it overpaid when its subscribers received emergency treatment or were referred to a Marshfield Clinic physician.

Plaintiffs' first argument is really an attempt to reintroduce the Section 2 monopolization claim struck down by the court of appeals. That issue has been resolved in full; plaintiff cannot reargue it. However, the second argument suggests how Compcare might have been damaged from the division of markets. Had Compcare made this argument during the trial on liability it might well be entitled to seek monetary relief for those damages. Having not done so, it is precluded by the law of the case from litigating a Section 1 claim at this time.

The court of appeals' reversal of all of Compcare's claims removes this plaintiff from the litigation. Only Blue Cross may proceed in the retrial of damages incurred by defendants' division of markets. All further references to plaintiff will be to Blue Cross only.

B. *Division of Markets*

The jury found that defendants divided markets in violation of Section 1 of the Sherman Antitrust Act. The court instructed the jury that it could find an illegal allocation of markets if it found a conspiracy to divide up customers between defendants and Rhinelander Medical Center *or* between defendants and certain hospitals *or* between defendants and North Central Health Protection Plan *or* between defendants and Wausau area physicians *or* between defendants and physicians affiliated with Security Health Plan. However, the verdict form did not require the jurors to identify those entities whom it found had conspired with defendants. The question (no. 7) asked merely

> Have defendants contracted, combined or conspired with a competitor or potential competitor to do any of the following in the relevant market?

a) Allocate customers?	Yes
b) Allocate territories?	Yes
c) Allocate product of service markets?	Yes
d) Fix fees or prices?	Yes

The district court held that there was enough evidence to support the jury verdict that Marshfield Clinic had divided markets and territory with all four entities. *Blue Cross,* 883 F. Supp. at 1259, 1267. (The court did not explain why the instructions included a reference to a fifth entity: physicians affiliated with Security Health Plan. It is questionable whether the doctors associated with defendant Security Health Plan could be found to have conspired with the plan and even more questionable that they could be characterized as competitors.) I will assume that there is no longer any question relating to the division of markets with respect to the doctors affiliated with Security Health Plan.

The court of appeals discussed the evidence of a division of markets with competitors and determined that there was enough evidence to sustain the jury's verdict "on this (and only this) aspect of the case . . . ." 65 F.3d at 1416. The court upheld the provisions of the injunction that forbade Marshfield Clinic from dividing markets with the Rhinelander Medical Center, Wasau area physicians, North Central, or Ministry Corporation hospitals, Gunderson Clinic and Rice Clinic and ordered a new trial limited to damages for dividing markets, with the burden on Blue Cross to show how much it would have paid Marshfield Clinic had the clinic not engaged in that illegal practice. *Id.* In discussing the adequacy of the "scanty" evidence, *id.*, it believed supported the claim of division of markets, the court focused only on the evidence relating to North Central. From this, defendants argue that the court affirmed the jury's finding on allocation of markets as to this one coconspirator only and that plaintiff should be limited on remand to proving the damages it sustained as a result of the one division of markets.

Defendants' argument does not stand up to close scrutiny of the court of appeals' decision. Although the court limited any detailed discussion of the evidence to matters involving North Central, it gave no indication that it found the evidence relating to the other coconspirators to be insufficient or that it disagreed with Judge Shabaz's conclusion that the evidence supported a finding of conspiracy to divide markets as to each of the four competitors named in the jury instructions. Had the court of appeals believed the evidence did not support a finding of conspiracy to divide markets with any competitor other than North Central, it would have said so explicitly. Defendants argue that the court of appeals' intention to confine plaintiff's victory to the one instance of defendants' agreement with North Central is shown by the court's use of the reference to a singular *division* of markets and its statement that it would be plaintiff's burden on retrial "to show how much less it would have paid the Clinic had the Clinic refrained from *that illegal practice*." *Blue Cross & Blue Shield,* 65 F.3d at 1417 (emphasis added). This argument is not persuasive. A division of markets can refer to one or a number of separate agreements; the overall conduct would still be referred to as a division. The phrase, "that illegal practice," can refer just as readily to a pattern of dividing up markets or to one instance of doing so. To the extent that plural and singular forms of nouns shed light on this question, I consider it determinative that when the court ordered a new trial, it limited that trial to "damages for dividing markets."

Expanding on their argument, defendants contend that the court found no legal or factual basis on which to uphold the other agreements to allocate markets; therefore, plaintiff is limited to recovering damages as a result of the defendants' agreement with North Central. Moreover, defendants contend, to expand liability to include the other agreements would not only contravene the remand order but violate their Seventh Amendment rights. The Seventh Amendment argument is simply another way of arguing that the evidence was too thin to support a finding of agreements with the other entities and that the jury's verdict is too ambiguous to allow plaintiff to assert damages as a result of any agreements other than North Central's. Defendants never challenged the verdict form or the instructions relating to this question on appeal and they cannot do so now. The form *is* ambiguous, but the ambiguity is no impediment to proceeding now that both the district court and the court of appeals have clarified its meaning. That the court of appeals did not discuss all of the evidence that would support a finding that each of the named competitors conspired to allocate markets does not mean that it found there was no such evidence.

C. *Plaintiff's Need to Prove Injury*

Defendants contend that in order to obtain any damages on retrial plaintiff will have to show that any damages its claims were caused in fact by illegal conduct. Defendants are correct. The court of appeals made that clear in its opinion when it stated that "[t]he burden will be on Blue Cross to show how much less it would have paid the Clinic *had the Clinic refrained from* [*improperly allocating markets*]." *Blue Cross & Blue Shield,* 65 F.3d at 1416 (emphasis added). In other words plaintiff will have to prove that it would have made lower payments to medical providers than it would have had the Clinic not allocated markets illegally. To the extent it cannot prove the higher payments were the result of acts that violated the antitrust laws and not of other legal factors, it will be unable to prove it was damaged.

D. *Effect of Remittitur on Plaintiff's Claim for Damages*

Acting on post-verdict motions, Judge Shabaz ruled that plaintiff had the option of choosing a remittitur that would reduce its award of damages to $595,883 or a new trial. Plaintiff chose the remittitur. Defendants contend that plaintiff is bound by that choice, even after appeal and remand, because defendants never challenged the amount of damages awarded to plaintiff. Plaintiff assert that defendants *did* appeal the damages award; defendants refute this vigorously and have sought permission to file a supplemental memorandum on that point, arguing that plaintiff did not make the assertion until its reply brief, when defendants would have no opportunity to respond to it under normal briefing procedures. However, there is no reason to permit defendants to file a supplemental memorandum on a point that is tangential to the decision.

The court of appeals determined that "[n]o part of the award of damages or of costs and attorneys' fees can stand, because these items were not segregated by offense," *id.* at 1416 and added that "[t]here must be a new trial limited to damages for dividing markets." *Id.* Once the damages award has been vacated, plaintiff cannot be held to a remittitur tied to the now non-existent award of damages. It may well be that defendants did not challenge the amount of the damages that plaintiff accepted as the cost of avoiding a new trial; yet the fact is that the result of its appeal of other aspects of the judgment resulted in the vacation of the damages award in its entirety. Defendants cannot be surprised that their challenge to the merits of the case resulted in the vacation of the remittitur; once they put the whole liability judgment into play, they assumed the risk that the damages award would be affected as well. Although defendants argue that the appellate opinion should be read as requiring a new trial for the sole purpose of determining what portion of the reduced amount of the origial damages award should be awarded as damages for the one remaining claim of division of markets, their argument is not supported by any language in the court's opinion.

Moreover, I see no reason why plaintiff should not be allowed to prove those items of damages, if any, that Judge Shabaz excluded because of his perception that plaintiff lacked standing to sue for those damages. In saying this, I do not imply that plaintiff may include in the damages calculation claims arising out of services it rendered in which it did not pay any insurance claims but merely passed through the expense to the employer. *See* discussion relating to administrative service contracts in *Blue Cross*, 883 F. Supp. at 1261.

E. *Viability of Plaintiff's Claim for Damages under Wis. Stat. § 133.14*

At the liability phase of trial, the jury found that defendants had violated Wis. Stat. § 133.03 (unlawful contracts; conspiracies). Before the case was submitted to the jury on damages, Judge Shabaz rejected plaintiff's attempt to seek damages under the penalty statute for § 133.03, Wis. Stat. § 133.14, which provides that when a violation of state antitrust law is proved, payments made under contracts found to be illegal may be refunded in full, regardless of the benefit the buyer has received. The parties disagree about Judge Shabaz's reasons for rejecting any question on damages under § 133.14. Plaintiff alleges that the judge's decision was based on his holding that plaintiff had no standing to seek damages arising out of the illegal contracts because those contracts were not between plaintiff and Marshfield Clinic but between the clinic and plaintiff's subscribers. Plaintiff contends that the jury's determination of liability under Wis. Stat. § 133.03 was not appealed and is the law of the case. Next, it argues that there is no need under Wis. Stat. § 133.14 for an additional finding that the contracts plaintiff made with defendants violated the antitrust laws because Wis. Stat. § 133.14 not only voids contracts made with conspirators but also those contracts made while Marshfield Clinic was a member of the conspiracy to allocate markets that grew out of or are directly or indirectly connected with the conspiracy. According to plaintiff, the court of appeals revived plaintiff's claim for damages under Wisconsin law when the court held that an insurer such as plaintiff has standing to sue for antitrust damages if it has paid the allegedly overcharging defendant directly, as plaintiff did.

Plaintiff's entire argument rests upon a mischaracterization of the district court's decision on plaintiff's request for damages under § 133.14. Judge Shabaz threw out the state law claim before submitting the case to the jury on damages, after concluding that plaintiff had failed to propose an instruction or a verdict question during the liability phase that would have had the jury make the predicate finding that plaintiff's contract with Marshfield Clinic was illegal. Trial transcript at 2802-17. Plaintiff dismissed its cross-appeal on this decision by the judge voluntarily. It never challenged the district court's decision not to submit any question to the jury on the damages to which it might be entitled under § 133.14 and cannot resurrect the issue on remand. *Barrow v. Falck*, 11 F.3d 729, 730 (7th Cir. 1993).

Furthermore, the court of appeals could not have reversed the district court ruling on this issue by implication. When the appellate court makes findings that contradict unappealed rulings it does not reverse these rulings. Unappealed issues become the law of the case even if the trial court's ruling would have been reversed if an appeal had been pursued. *Ohio-Sealy Mattress Mfg. Co. v. Sealy, Inc.*, 669 F.2d 490, 493 (7th Cir. 1982), *cert. denied*, 459 U.S. 943 (1982). Plaintiff attempts to avoid the force of this rule by arguing that Judge Shabaz's decision was appealed in effect when defendants raised the broader question of plaintiff's standing to bring this action. Defendants argued that such standing was lacking because the contracts were not between plaintiff and Marshfield Clinic but solely between the subscribers and Marshfield Clinic. Therefore, plaintiff argues, when the court of appeals held that plaintiff had standing to sue because each payment was a contract between plaintiff and Marshfield Clinic, *Blue Cross & Blue Shield*, 65 F.3d at 1414, it overruled Judge Shabaz's ruling on Wis. Stat. § 133.14, making a new trial on the issue of damages under Wis. Stat. § 133.14 consistent with the appellate opinion.

Again, plaintiff's argument mischaracterizes what happened. Defendants did not appeal any aspect of the trial court's decision not to submit a question to the jury on damages under state law. That decision was never appealed. It is the law of the case and it prohibits the jury in the new trial from considering any award of damages under Wis. Stat. § 133.14 for the violation of § 133.03.

ORDER

IT IS ORDERED that the motion of defendants Marshfield Clinic and Security Health Plan to file and serve a supplemental memorandum is DENIED as unnecessary. FURTHER, IT IS ORDERED that the retrial of this case shall be limited as follows:

1) Compcare Health Services Insurance Corporation is no longer a party to the suit;

2) Plaintiff may seek damages for injuries it can prove it sustained as a result of the illegal allocation of mar-

kets between defendants Marshfield Clinic and Security Health Plan and its competitors, North Central Health Protection Plan, Rhinelander Medical Center, Wausau area physicians and certain hospitals in the Ministry Corporation;

3) Plaintiff's damages are not limited in amount to the remittitur it accepted in lieu of a new trial; and

4) Plaintiff may not recover damages pursuant to Wis. Stat. § 133.14.

Entered this 10th day of September, 1996.

BY THE COURT:

/s/ Barbara B. Crabb
BARBARA B. CRABB
District Judge

APPENDIX E

[Filed Sep. 10, 1996]

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF WISCONSIN

94-C-137-C

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN,
Plaintiff,
v.
THE MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.
Defendants.

ORDER NO. 2

Plaintiff Blue Cross & Blue Shield United of Wisconsin having established that defendants Marshfield Clinic and Security Health Plan of Wisconsin, Inc. entered into illegal agreements with competitors to allocate markets or threatened to enter into such contracts, IT IS ORDERED that:

1. Any agreements, understandings and contracts, whether written, oral or otherwise, concerning the allocation of customers, territories, product or service markets, with any competing plans or groups, including but not limited to North Central Health Protection Plan, are DECLARED to be void and of no effect; and

2. Defendants Marshfield Clinic and Security Health Plan of Wisconsin, Inc. are ENJOINED AND RESTRAINED from forming or joining any contract, combination or conspiracy concerning the allocation of customers, territories, product or service markets, with any

competing plans or groups, including but not limited to North Central Health Protection Plan.

3. Nothing in this order shall be construed to prohibit or invalidate any agreement that would be lawful under the antitrust laws as a reasonable restraint ancillary to a legitimate joint venture.

4. Defendants are to send, by first-class mail, postage pre-paid, a copy of this order to the following persons within thirty (30) days of the entry of this order:

A. North Central Health Protection Plan;

B. All physicians practicing in the city of Wausau and any medical clinics located in the city of Wausau;

C. Rhinelander Medical Center;

D. Gunderson Clinic;

E. Rice Clinic; and

F. Ministry Corporation.

Entered this 10th day of September, 1996.

BY THE COURT:

/s/ Barbara B. Crabb
BARBARA B. CRABB
District Judge

APPENDIX F

[Filed Apr. 1, 1997]

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

94-C-0137-C

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN,
Plaintiff,
v.

THE MARSHFIELD CLINIC and SECURITY HEALTH
PLAN OF WISCONSIN, INC.,
Defendants.

OPINION AND ORDER

This case is scheduled for retrial on the sole issue of damages, following remand from the court of appeals. It is before the court because defendants Marshfield Clinic and Security Health Plan of Wisconsin, Inc., have moved for summary judgment, arguing that it is clear from the export reports filed by plaintiff Blue Cross & Blue Shield United of Wisconsin that plaintiff cannot prove any actual damages. The motion is more aptly characterized as a motion in limine designed to give the court an opportunity to rule in advance of trial on the admissibilty of evidence and this is how I will consider it.

This case was tried originally in December 1994 and January 1995, with the Honorable John C. Shabaz presiding. Plaintiff Blue Cross & Blue Shield United of Wisconsin and its subsidiary, a health maintenance organization known as Compcare Health Services Insurance Corporation, sued defendants Marshfield Clinic and Security

Health Plan, charging that they had violated the Sherman Antitrust Act by dividing markets and fixing prices in violation of 15 U.S.C. § 1 and by monopolizing the delivery of medical services in a manner that excluded Compcare from the health maintenance organization market in certain counties of north central Wisconsin, in violation of 15 U.S.C. § 2. The jury found that defendants had committed a number of antitrust violations that affected plaintiff and Compcare, by monopolizing the health maintenance organization market, charging supracompetitive prices to patients insured by plaintiff, dividing markets and taking other illegal acts. On appeal, the Court of Appeals for the Seventh Circuit threw out Compcare's claims of injury and all but one of plaintiff Blue Cross's theories of antitrust injury, holding that only the evidence of a division of markets was sufficient to sustain the jury's verdict. *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic,* 65 F.3d 1406, 1415-16 (7th Cir. 1995), *cert. denied,* 116 S.Ct. 1288 (1996). It remanded the case to this court for a new trial "limited to damages for dividing markets." *Id.* at 1416. Because plaintiff's one remaining claim can be asserted only against The Marshfield Clinic and not its subsidiary, Security Health Plan, which is a health maintenance organization and not an entity to which plaintiff would have made payments under its indemnity insurance policies, I will refer only to defendant Marshfield Clinic throughout the remainder of this opinion.

At the first trial, the jury found that plaintiff had incurred injuries of $10,500,000 when it paid defendant's supracompetitive prices under its indemnity insurance contracts or as disbursing agent under other kinds of contracts, primarily "administrative services only" and "cost plus" contracts ("administrative contracts" for short). For the administrative contracts, plaintiff took on the administration of the contracts for self-insured companies but had no liability for payment (other than an attenuated liability on the cost plus contracts under which plaintiff would be liable in the event the company went bankrupt or if the costs exceeded a certain payment ceiling). In a posttrial order, Judge Shabaz granted defendant's motion for a new trial unless plaintiff accepted a remittitur. *Blue Cross & Blue Shield United of Wisconsin v. The Marshfield Clinic*, 883 F. Supp. 1247, 1261 (W.D. Wis. 1995). He based the amount of the remittitur for plaintiff Blue Cross on the amount of damages testified to by plaintiff's expert, John Beyer, noting that Beyer's testimony was credible because he had considered overcharge fees in the context of markets identified by another expert and found by the jury to constitute relevant, existing markets. *Id.* at 1260. Judge Shabaz contrasted Beyer's testimony with that of another of plaintiff's experts, whose testimony he found to be incredible because it was not related to any relevant market. *Id.* In instructing the remittitur as it related to overcharges by the defendant clinic, Judge Shabaz gave plaintiff the choice of a new trial or damages against defendant in the amonut of $594,833, which was the amount supported by Beyer's tetstimony ($1,085,897), reduced by the amount attributed to the administrative contracts. Judge Shabaz made the reduction after finding that the jury's verdict demonstrated that it had rejected plaintiff's claim that it was entitled to any damages for overcharges on the contracts it merely administrated and for which it was not at risk. Plaintiff did not appeal Judge Shabaz's decision that it was not entitled to damages related to the administrative contracts.

After the case was remanded, defendant argued unsuccessfully that plaintiff's decision to accept the remittitur set a cap on the damages it could seek in the retrial. The argument was rejected on the ground that defendant had put the damages award at risk when it challenged the entire liability judgment. *Blue Cross & Blue Shield United of Wisconsin v. The Marshfield Clinic*, 94-C-137-C, Opin.

and Order No. 1 at 11 (Sept. 10, 1996). However, I noted explicitly that this ruling did not mean that plaintiff could include in any damage calculation claims arising out of services rendered in connection with the administrative contracts. *Id.*

It appears from the expert reports that plaintiff has filed in preparation for the new trial on damages that it views as a magnanimous invitation the small window of opportunity left it by the court of appeals and by the September 10, 1996 order. Far from taking the $594,833 as a starting point from which it would attempt to show how much of that amount was attributable to the anticompetitive action that the court of appeals had found to be a true antitrust violation, plaintiff computed its damages from scratch, with a new definition of market and two wholly new constructs of damages, each amounting to more than $7,000,000. Not surprisingly, defendant finds this objectionable. It argues that no foundation exists for the damage determinations in the expert reports and that plaintiff cannot prove any damages at trial, for three reasons: 1) plaintiff has not linked its damages to the findings of the first jury on liability; 2) plaintiff has not proved antitrust injury caused by a harm to competition; and 3) plaintiff has not disaggregated from its claims those "injuries" that are attributable to legal causes.

A. *Administrative Contracts*

At the outset, it is necessary to make it more explicit than I thought I did in the September 10, 1996 order: plaintiff may not claim damages relating to the contracts for which it provided only administrative services. Judge Shabaz has ruled that the jury denied plaintiff damages for these contracts. Plaintiff never appealed this decision, and for good reason. Try as it might, plaintiff cannot transform its role as an administrator of a contract into that of the buyer of a product. As an administrator, it has no standing to seek damages for supracompetitive prices for which it assumed no risk. Plaintiff cites *Illinois Brick Co. v. Illinois,* 431 U.S. 720 (1977), and *Hanover Shoe, Inc. v. United Shoe Machinery Corp.,* 392 U.S. 481 (1968), as authority for its poistion that it can be warded damages, but these cases are inapposite. They distinguish between direct and indirect purchasers of allegedly overpriced products, holding that only the direct purchasers can sue the antitrust violator; the indirect purchasers are barred from suing, even if the direct purchasers passed through the entire overcharge. In addition, plaintiff cites *Kansas v. Utilicorp United, Inc.,* 110 S. Ct. 2807, (1990), and *Illinois ex rel. Burris v. Panhandle Eastern Pipe Line Co.,* 935 F.2d 1469 (7th Cir. 1991), for the proposition that indirect purchasers cannot sue an alleged violator even if they are customers of direct purchasers who buy the overpriced product pursuant to a cost plus contract that enables them to pass along all of the excess charges. Plaintiff would characterize itself as a direct purchaser, passing through the excess charges to the employer groups that contracted with it to administer their health benefits, but the fact is that plaintiff was not the purchaser of defendant's product. The employer groups were the purchasers; plaintiff simply acted as their agent. *See Blue Cross,* 883 F. Supp. at 1261 (under administrative service contract, plaintiff simply processed claims and charged fees for the processing; employer groups bore the risk of loss).

The court of appeals did not hold that plaintiff could recover the payments made under the administrative contracts. Plaintiff argues that it did, but a close look at the court's discussion of plaintiff's standing to seek damages for overcharges makes it clear that the court was addressing only plaintiff's standing to seek damages for the payments it made under its indemnity contracts. In rejecting defendant's argument that plaintiff had no standing because its fee-for-service contracts were with the patients themselves, the court looked at the agreements under which defendant was paid for patient services: "[T]he money went directly from Blue Cross to the Clinic . . . each payment and acceptance was a completed contract. We do not think more is required to establish Blue Cross's right to sue to collect these overcharges." *Blue Cross*, 65 F.3d at 1414-15. The court of appeals had no reason to address the administrative contracts because the issue of those contracts was never before it. Had it done so, it would have looked to the source of the payments for defendant's services, which in the case of the administrative contracts, was not plaintiff but the employer groups that retained plaintiff as an administrator. In the court of appeals' view of the relationship among patient, payor and provider, the employer group was the direct purchaser under the administrative contracts in the way that plaintiff was under the indemnity contracts.

Plaintiff would have standing to sue for any payments made under the administrative contracts to the extent those payments came from its own pocket, as would be the case if charges exceeded the cap on a particular stop loss contract. However, the time for establishing that standing was at the first trial. The issue has been decided adversely to plaintiff. It will not be reopened at the new trial.

B. *The Question of Market and Market Power*

At the first trial, plaintiff called Warren Greenberg as an expert witness to identify nine primary care markets, some pediatric markets and 14 specialty care markets as those in which defendants had market power. When plaintiff's damage expert, Beyer, testified later in the trial about the damages that plaintiff had incurred from the supracompetitive prices defendant had charged, he related the amount of overcharges to those markets. The jury found that plaintiff had proved that HMO services, primary care, pediatric care and one or more specialty care markets were "relevant product and geographical markets" (verdict question no. 1) and that defendant had conspired to allocate customers, territories, product or service markets and fix fees and prices in a "relevant market" (verdict question no. 7). In the posttrial order, Judge Shabaz found that the testimony supported the jury's finding in question no. 7 as it related to the allocation of markets with Ministry Corporation, North Central Health Protection Plan, Rhinelander Medical Center and Wausau area physicians. *Blue Cross,* 883 F. Supp. at 1259.

Discussing the HMO markets and the other markets Greenberg identified in terms of Compcare's monopolization claims, the court of appeals held that HMOs did not constitute an independent market and that the specialty care markets were not true "markets" because they were defined in terms of narrowly specialized procedures unrelated to conditions of supply in the geographic market. Plaintiffs' allegations of monopolization of pediatric and primary care failed because of its inability to show that defendant employed 50 percent or more of the physicians within the market.

For the retrial, plaintiff has abandoned any attempt to relate its damages to the markets it identified in the first trial. It maintains that it may seek damages for the anticompetitive effects of market division upon the entire array of physician services offered by defendant without limitation to the four specific markets identified at trial because 1) the first jury's finding of the four specific markets of HMO services, pediatric care, etc., related only to its finding of monopoly in response to question no. 1 of the verdict, not to question no. 7, which concerned division of markets; 2) as to question no. 7, the jury was instructed that it could find antitrust violations if it found that defendant conspired with others to allocate "territories or geographical areas in which they would otherwise have competed in the sale of *managed products, physician's services, or other services and products,*" *see* Jury Instructions, "Antitrust Injury," dkt. #475 (emphasis added); 3) Judge Shabaz's comments in deciding the posttrial motions show that he did not believe that the relevant markets identified in the answer to question no. 1

limited the markets that had been allocated illegally: he noted that defendant's illegal division of markets with Ministry Corporation involved outpatient care and urgent or emergency care, aspects of services that were not included in the four specific markets, *Blue Cross,* 883 F. Supp. at 1267; and 4) the court of appeals affirmed defendant's liability for the division of an HMO market when it had rejected the existence of such a market in deciding monopolization, showing, in plaintiff's eyes, that it did not confine the division of markets inquiry to the four identified in response to verdict question no. 1.

Plaintiff disparages the importance of identifying the market or markets that defendant divided and establishing deefndant's market power within each market, arguing that this is unnecessary when proving a pro se violation, as it did in this case. Plaintiff's proposition is correct, *see, e.g., Israel Travel Advisory Services, Inc. v. Israel Identity Tours, Inc.*, 61 F.3d 1250, 1256 (7th Cir. 1995) (price fixing and market allocation do not require proof of market power); *Blackburn v. Sweeney,* 53 F.3d 825, 827 (7th Cir. 1995) ("Horizontal agreements to allocate markets are *per se* violations of § 1 of the Sherman Act."), but irrelevant at this stage of the proceedings. The fact is that market identification and showing that defendant had market power *are* required when it comes to proving damages under § 4 of the Clayton Act, 15 U.S.C. § 15. *See, e.g.,* William M. Landes & Richard A. Posner, *Market Power in Antitrust Cases,* 94 Harv. L. Rev. 937, 938 (1981) (noting necessity of proving effect on prices in private antitrust action, that is, proof of exercise of market power, and explaining that standard manner of proving market power begins with defining a relevant market in which to compute plaintiff's market share and then computing that share and deciding whether it is large enough to support an inference of required degree of market power). If defendant did not have market power in the relevant market or markets, plaintiff could not prove that defendant caused it injury. *See id.* at 955;

see also Subsection C of this opinion (discussing causation requirement in proving damages).

Common sense supports this conclusion. Consider a hypothetical situation in which a supermarket chain that established that its soft drink suppliers had violated the antitrust laws by dividing the market for supplying Pepsi Cola (a non-substitutable product in the eyes of many). Although the chain could prove liability, it could not recover damages for overcharges for other soft drinks not shown to constitute a product market or for Pepsi Cola purchases by stores outside the geographical limit of the violators' agreement, and could not recover any damages at all unless it could show the two suppliers had market power. Without market power, the two suppliers would be unlikely to be able to charge supracompetitive prices without losing business to competitors. Thus, it would be necessary for the chain to show how the antitrust violators had such market power that the chain had no option but to pay the violators' overcharges. It cannot do this unless it can define the market.

Determining what plaintiff must prove is the easy part; the hard part is determining what has been proved in light of the evidence adduced at the first trial, Judge Shabaz's opinion and the court of appeals' decision. Contrary to defendant's assertions, plaintiff established at the first trial that defendant has market power in the relevant market or markets. The jury in the first trial was instructed that market power is an element of a § 1 offense, *see* "Elements of a Section One Offense," Jury Instructions, dkt. #475, and found defendant liable under § 1 for market division, a decision affirmed by Judge Shabaz and the court of appeals. Determining what the relevant market or markets are in light of the court of appeals' decision is not so clear. After all, the court of appeals seemed to reject the idea of treating certain specialties as separate markets, *Blue Shield,* 65 F.3d at 1411, on the ground that the classifications Dr. Greenberg chose (diagnostic related groups) are unrelated to conditions of supply. Moreover, it held that HMO services were not sufficiently unique or non-substitutable as to constitute a separate market and it found no monopoly as to pediatric and primary care markets because defendant did not employ fifty percent or more of the physicians providing those services in the relevant geographical areas. *Id.* at 1412. However, the court made these observations when discussing the flawed monopolization claims of Compcare, not plaintiff Blue Cross's claim of dividing markets. In affirming the sufficiency of that claim, the court of appeals spoke specifically about the agreement between defendant and North Central Health Protection Plan to divide markets for HMO subscribers. *Id.* at 1415-16. Had the court believed that HMO services could not be a "market" for purposes of the division of markets claim, it would hardly have used division of these markets as an example of a viable claim. Presumably, two competitors can violate the antitrust laws if they conspire to divide up a market, even if neither one alone had power to set prices in that market. The fact that each might provide substitutes for the other does not mean the market is an open one if the substitutes are the subject of the illegal market division. From the court of appeals' decision to remand this aspect of the case, I draw the conclusion that the court did not think that defendant and its conspirators lacked sufficient power to set prices in the markets plaintiff had identified during the first trial.

If I were to agree with plaintiff that the court of appeals had ruled that plaintiff's previously identified markets were not markets in which plaintiff could exercise any power, plaintiff would have a greater problem than it now faces. Plaintiff never proved any markets other than the ones the jury found in response to question no. 1 (HMO services, specialty services, pediatric care and primary care). It is all very well for plaintiff to argue that "the jury was free to consider *any* markets including not only the four specified in Special Verdict Q. 1, but also general physician services of the territorial allocation instruction, outpatient on [sic; and? or?] urgent care as noted by the Court, as well as any other market it believed fit the requirements," Plt.'s Brief in Opposition to Motion for Summary Judgment on Damages, dkt. #720, at 45 n.27, but without a citation to the record to show the evidence that would have supported such a finding by the jury, the argument goes nowhere. The jury was instructed that in order to answer verdict question no. 1 (whether plaintiff had established one or more of the following relevant product and geographical markets), it had to identify specific products or services, find that the products or services were good substitutes for each other and identify the geographic boundaries of effective competition. The only witness plaintiff presented to render opinions identifying relevant markets was Dr. Greenberg, who testified that he had done no analysis that would enable him to render an opinion about the effect on competition in a market that would include all physician services and that he was not in a position to say that it would be rational from an economic standpoint to define a market made up of all those services. Trial tr. at 779.

Plaintiff would draw support for its position that it is not bound by the markets found in the first trial from Judge Shabaz's comment with respect to the Ministry Corporation. However, Judge Shabaz's reference to emergency care, urgent care and outpatient care was made in the context of considering the propriety of injunctive relief, not for determining whether plaintiffs had identified a market in these services so as to sustain a claim of actual damages.

Plaintiff proved a violation of § 1 of the Sherman Act in the liability phase of the first trial. Now it must prove how the violation caused it injuries. Since it identified only four markets in the first trial that met the definition of relevant market in the court's instructions and since the jury found that defendant divided only those markets, plaintiff must limit its proof of damages at the new trial on damages to the anticompetitive effects of defendant's allocation of those markets.

C. *Failure to Link Damages to Injury and the Disaggregation Requirement*

Two more hurdles remain for plaintiff to establish that it is entitled to damages. First, plaintiff must prove with a fair degree of certainty that defendant's market division was a material element of some injury to plaintiff and a substantial factor in producing that injury (the "fact of injury"). *Greater Rockford Energy & Technology v. Shell Oil*, 998 F.2d 391, 401 (7th Cir. 1993); *Moore v. Boating Industry Associations*, 754 F.2d 698, 717 (7th Cir. 1985), *vacated on other grounds*, 474 U.S. 895 (1985); *Blue Cross*, 883 F. Supp. at 1261. Second plaintiff must make a "just and reasonable" estimate of the amount of damages. *Moore*, 754 F.2d at 717; *MCI Communications v. American Telephone and Telegraph Co.*, 708 F.2d 1081, 1161 (7th Cir. 1983).

According to the Supreme Court, the factfinder may find the fact of injury "as a matter of just and reasonable inference from the proof of defendants' wrongful acts and their tendency to injure plaintiff's business" as long as plaintiff's injury is not attributable to some other intervening market force. *Bigelow v. RKO Radio Pictures, Inc.*, 327 U.S. 251, 264 (1946); *Greater Rockford*, 998 F.2d at 395. The antitrust violation need not be the sole cause of plaintiff's injuries, but plaintiff must show that "but for" the violation, the injury would not have occurred. *Greater Rockford*, 998 F.2d at 401.

"The proof required to show causation of damages is greater than that required to prove amount of damages, where a plaintiff is afforded more latitude due to the 'vagaries of the marketplace,'" *Greater Rockford*, 998 F.2d at 401, but plaintiff's damage evidence must not result in a jury verdict that is the product of speculation or guesswork. *MCI*, 708 F.2d at 1161 (citing *J. Truett Payne Co. v. Chrysler Motor Corp.*, 451 U.S. 557, 566-67 (1981); *Zenith Radio Corp. v. Hazeltine Research Inc.*, 395 U.S. 100, 123-24 (1969)). Evidence of damages has been held to be speculative if it fails to disaggregate to account for factors other than illegal conduct. *See, e.g., Isaksen v. Vermont Castings, Inc.*, 825 F.2d 1158, 1165 (7th Cir. 1987); *MCI*, 708 F.2d at 1164-65. Plaintiff does not have to disaggregate damages among individual market division agreements, but it does have to identify those losses directly attributable to market division. *Story Parchment Co. v. Paterson Parchment Paper Co.*, 282 U.S. 555 (1931) (not necessary to separate damages attributable to multiple antitrust violations); *MCI*, 708 F.2d at 1161. Therefore, even in proving the amount of damages, plaintiff must be able to trace its damages to the injury caused by defendant's market division. *See Greater Rockford*, 998 F.2d at 401 n.14 (citing *MCI*, 708 F.2d at 1168).

Plaintiff seems to argue that causation was established in the first trial and affirmed on appeal. *See* Plt's Brief, dkt. #720, at 34 (citing *Blue Shield*, 65 F.3d at 1415-16; *Blue Cross*, 883 F. Supp. at 1259). If this is its position, it is mistaken. Although the jury was instructed on the fact of injury during the liability phase of the first trial, *see* Jury Instructions, "Antitrust Injury," dkt. #475, the liability special verdict does not indicate that the jury made any findings relating to fact of injury from market division. The jury was asked only whether defendant had "contracted, combined, or conspired" to allocate customers, territories, or product or service markets. *See* verdict question 7, dkt. #476. The affirmative response to that question established only the existence of an illegal agreement, not the fact of injury. The jury was instructed again on causation during the damages phase of the first trial, *see* Jury Instructions, "Antitrut Injury," dkt. #477, and was asked to determine "what amount of money if any would compensate plaintiff Blue Cross for any antitrust injury which it sustained on or after February 16, 1988 which is the direct result of defendants' conduct in violation of the antitrust laws as found by you," *see* verdict question no. 1, dkt. #478. In selecting a monetary amount, the jury necessarily determined that plaintiff had been injured in fact. However, as the court of appeals noted, the verdict form did not ask the jury to distinguish between its previous findings of liability for illegal market division and the other illegal conduct it had found. *See id.* As a result, on retrial, plaintiff must establish both 1) causation (that defendant's market division was a material element and substantial factor in producing injury to plaintiff) and 2) a just and reasonable estimate amount for damages.

Plaintiff relies on the expert reports of Thomas McGuire and John C. Beyer to show that defendant's illegal market division resulted in overcharges for various services and products (the fact of injury) in excess of six million dollars (amount of damages) for the period in question. Defendant argues that these experts have lumped together all price increases without identifying those that are the result of illegal acts and separating them from legitimate price increases resulting from the higher quality of its services and products and acts previously found to be legal, *see Blue Shield,* 65 F.3d at 1415. Defendant contends that the failure to disaggregate these factors makes it impossible for plaintiff either to prove causation or provide a just and reasonable estimate of damages.

The parties engage in considerable debate over the importance of quality as a factor in defendant's alleged overcharges; both of plaintiff's experts maintain that they have accounted for this factor in selecting their benchmarks. Defendant has raised valid concerns about Beyer's report, in which he compares defendant's prices to the average price charged by the providers in the County of Eau

Claire and by providers statewide. Beyer asserts that Eau Claire is a comparable market, but he has not shown that the individual providers in Eau Claire are comparable to defendant in size or quality. As a result, it is difficult to determine how defendant differs from the individual Eau Claire providers in terms of quality. McGuire argues in his rebuttal report that defendant has not offered empirical proof of its quality in relation to other providers and that the uncertainty in plaintiff's damage calculations should rest on defendant. *See Zenith,* 395 U.S. at 124-25. Although McGuire's argument ignores the emphasis plaintiff placed upon defendant's quality in the first trial, I would be inclined to allow the jury to weigh the evidence and reach its own conclusions about the significance and effect of quality. However, the point is probably moot. The treatment of quality as a pricing factor is debatable, but it is not debatable that plaintiff's experts must separate out of their damage calculations the conduct found illegal by the jury in the first trial but later found to be legal by the court of appeals.

It is difficult not to view plaintiff's expert reports with a jaundiced eye, given the huge discrepancy between the current damage calculations and those offered in the first trial. In the first trial, Beyer estimated that defendant's illegal monopoly, market division activities, price fixing and boycotting resulted in total damages of $594,000 caused plaintiff by defendant (excluding amounts attributable to ASO contracts). *See Blue Cross,* 883 F. Supp. at 1260. For the retrial, Beyer and McGuire have calculated that the damages resulting solely from market division are approximately seven times higher than the amount of damages caused by market division together with monopoly, price fixing and other illegal acts.

McGuire does not discuss defendant's natural monopoly or its other legal conduct in his expert and first rebuttal expert reports. However, in his supplemental rebuttal report, he states that he accounted for defendant's lawful competition and concluded from his analyses, which included variable controlling for defendant's market share, that the lawful conduct had no effect on defendant's prices.[1] Despite the possibility that defendant's market share may be related to its legal conduct, McGuire does not explain the relationship or discuss any specific conduct of defendant.

I have concerns also about McGuire's method of calculating damages. McGuire measures as damages what he admits may be the result of an increase in quantity, calculating the total average annual payment that plaintiff made per patient. As defendant notes, McGuire's estimated overcharges may be the result of an increase in price, an increase in quantity or both. McGuire asserts that it is necessary to look at payments per patient per year rather than prices charged by defendant. In his opinion, it is irrelevant whether plaintiff's payments to defendant per patient increased because of higher charges for few visits or fewer services or because the patient saw the doctor more frequently and received more services. He acknowledges that in most situations, an increase in "outputs" (products or services sold) is an indication that prices are competitive, but he contends that this rule does not hold true in the field of medical services because the consumer's "demand" for additional services is not a reflection of a competitive price and a desire to have more services, but a "physician-induced demand." Consumer-patients do not make independent decisions about the need for medical services; they merely agree to the recommendations of their doctors, who in this case are able to charge supracompetitive prices and have an incentive to sell as many services as they can at these prices. For this reason, McGuire concludes, the amount of services given to each patient does not necessarily reflect competitive activity and should not be treated as such.

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[1] In a supplemental rebuttal report, McGuire also states that he has modified his model to further address defendant's concerns over causation. However, the second supplemental rebutal report was submitted after briefing was complete on the motion for summary judgment. Defendant has not had an opportunity to respond to the modification of McGuire's model and I have not considered it.

Although McGuire argues that his assumption of increased output reflects basic price theory ("When supply price goes up, the rational seller supplies more." Suppl. and Second Rebuttal Report of Thomas McGuire, dkt. #767, at 2), he has not shown that his use of payments per patient is an acceptable method of measuring antitrust damages. As defendant asserts, most of the case law supports the position that anti-competitive conduct typically results in an increase in prices to consumers which is coupled with a direct or indirect reduction in output. *See Stamatkis Industries, Inc. v. King,* 965 F.2d 469, 471 (7th Cir. 1992); *General Leaseways v. National Truck Leasing Association,* 744 F.2d 588, 594 (7th Cir. 1984). Antitrust violators either restrict their supply of services and products directly or do so indirectly by raising prices to a point at which consumers buy less. *See General Leaseways,* 744 F.2d at 594.

McGuire may be correct in this approach, but he has failed to show that it is one that is generally accepted. More important, McGuire does not cite to any evidence from which a jury could infer that this defendant took actions either to increase the use of unnecessary services or failed to take action to lessen the use of such services. It would be interesting, at the least, had McGuire compared the services defendant provided patients whose charges were covered by plaintiff or some other third-party payor (as to whom McGuire says defendant had an incentive to increase sales of services) with services provided members of Security Health Plan, defendant's subsidiary (as to whom defendant's physicians have a strong incentive to minimize services in order to maximize their profits). In short, I am not persuaded that McGuire has provided sufficient evidence to allow the jury to decide the validity of his use of payments rather than charges as the basic unit of comparison. *See MCI,* 708 F.2d at 1165 (plaintiff "must substantiate adequately the assumptions which provide the foundation for the [expert] study.").

Beyer does not account for the effects of defendant's legal acts, but asserts that the impact of defendant's illegal market division was stronger than he had realized during the initial stages of the first trial. In fact, he thinks now that defendant's illegal market division "became strong enough to stand as not just bad conduct consistent with monopoly power, but as independent antitrust violations [as found by the court of appeals]," and assumes that any observable overcharges result solely from illegal market division. Rebuttal Report of John C. Beyer at 8. Neither Beyer nor plaintiff cites anything in the record to support Beyer's assumption that the consequences of the illegal market division outweigh any effects of the other, legal conduct of defendant. The report "must be rejected as inherently untrustworthy and lacking in foundation." *MCI,* 708 F.2d at 1165.

Because neither Beyer or McGuire offers any means of accounting for defendant's legal conduct, their calculations would not assist the jury, but would require it to speculate. In remanding this case for retrial on damages, the court of appeals made it plain that the "burden will be on Blue Cross to show how much less it would have paid the Clinic had the Clinic refrained from the illegal practice." *Blue Shield,* 65 F.3d at 1416. Even if a jury could infer fact of injury, that is, *but for* defendant's market division, plaintiffs would have paid lower prices, plaintiffs must disaggregate the contributions made to the alleged overcharge by the illegal market division and by the legal conduct. *See U.S. Football League v. National Football League,* 842 F.2d 1335, 1378-79 (2d Cir. 1988) (plaintiff must provide jury with reasonable basis on which to estimate amount of losses caused by other factors). Neither Beyer or McGuire provides the jury with any way to adjust the amount of damages to reflect the effect of defendant's lawful conduct, despite the appellate court's clear instruction. *See Isaksen,* 825 F.2d at 1165; *MCI,* 708 F.2d at 1165.

The court of appeals has held repeatedly that "[w]hen a plaintiff improperly attributes all losses to a defendant's illegal acts, despite the presence of significant other factors, the evidence does not permit a jury to make a reasonable and principled estimate of the amount of the damage." *MCI,* 708 F.2d at 1162; *see also Schiller & Schmidt, Inc. v. Nordisco Corp.,* 969 F.2d 410, 415 (7th Cir. 1992); *Isaksen,* 825 F.2d at 1165. In *MCI,* the court of appeals affirmed only part of the jury's liability findings and remanded the case to the district court for a retrial on damages, *id.* at 1167-68, after determining that the damage calculations in evidence did not provide the jury with a means of adjusting damages to reflect what the court had found to be legal conduct on the part of defendant. *Id.* at 1163. In remanding the case, the court indicated that plaintiff's "evidence must provide for impairments or losses stemming from competition that has been found to be lawful" and plaintiff must be able rationally to "disaggregate its proof of damages" among illegal and legal conduct. *Id.* at 1168.

This case differs from *MCI* because plaintiffs have offered new damage calculations, but the recalculations do not account for what the court of appeals found to be defendant's legal conduct. In fact, the new estimates are substantially greater than those in the first trial, even though there is now less illegal conduct to be considered. Without some reasonable means for accounting for the legal conduct, a jury could not be fairly certain that defendant's illegal market division was the "but for" cause of plaintiffs' alleged overpayments and could not reach a verdict on damages that was not the product of speculation or guesswork. "*Post hoc ergo propter hoc* is not a valid methodology of damage calculation, especially when it is apparent that other factors are at work." *Isaksen,* 825 F.2d at 1165; *see also Nordisco,* 969 F.2d at 415 (expert should have tried to separate damages resulting from lawful and unlawful conduct).

ORDER

At the new trial, plaintiff is constrained to tie its proof of actual damages to the markets identified at the first trial. The damage reports of Beyer and McGuire filed before briefing was complete on this motion are inadmissible because they do not distinguish between the contributions to defendant's increased prices of defendant's legal conduct and the illegal conduct of dividing markets.

Entered this 1st day of April, 1997.

BY THE COURT

/s/ Barbara B. Crabb
BARBARA B. CRABB
District Judge

APPENDIX G

UNITED STATES DISTRICT COURT
W.D. WISCONSIN

No. 94-C-0137-C

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN

v.

THE MARSHFIELD CLINIC AND
SECURITY HEALTH PLAN OF WISCONSIN

April 7, 1997

OPINION AND ORDER

CRABB, Judge:

In an order entered herein on April 1, 1997, I construed defendants' motion for summary judgment as a motion in limine on the admissibility of certain expert reports and held that the reports were inadmissible. A hearing to clarify that order and the status of the case for trial was held today, April 7, 1997, by telephone. Plaintiff was represented in the telephone conference by James Troupis and Jon Furlow. Barbara Van Dam was also present. Defendants were represented by Thomas Cullen and Kevin McDonald. After giving plaintiff ample opportunity to advise the court of what it would be able to introduce at trial on the essential issue of the retrial, the amount of damages plaintiff incurred as a result of defendants' illegal division of markets in health maintenance organizations, pediatric care, primary care and certain specified specialty care areas, I conclude that entry of summary judgment for defendants was proper. Plaintiff has no evidence it can introduce at trial that would enable the jury to make an informed decision about the amount of damages, if any, that it suffered from the antitrust violations at issue.

Plaintiff asserted that certain portions of its experts' reports were not covered by the April 1 order and would be admissible. They stated, for example, that its experts could testify about the discounts that defendant Marshfield gave to entities with which it had divided markets or that were located in areas in which defendant had competition. In addition, the experts could testify to their observations of the way in which the market agreements between potential HMO competitors affected the prices of primary care and pediatric care markets, about defendant's practice of pegging its prices in 80% of the usual and customary rates charged by medical providers and about the way in which the medical market is different from every other market because the consumer-patient chooses the services but is not the actual purchaser of them, because of third party payor arrangements. It is not necessary to decide at this time whether this evidence would be relevant and otherwise admissible. Even if it were, it does not supply the jury with what it needs, which is a method for computing "how much less [Blue Cross] would have paid the [Marshfield] Clinic had the Clinic refrained from [dividing markets]." *Blue Cross & Blue Shield v. The Marshfield Clinic* [1995-2 TRADE CASES ¶ 71,120], 65 F.3d 1406, 1416 (7th Cir.1995).

The information that defendant gave discounts to potential competitors and to certain large entities and that defendant set its prices at a level predetermined by plaintiff's usual and customary charges may well have some probative value, but it is far short of what a jury would need to make a final determination. Moreover, it is questionable whether the few examples of discounting are sufficient to allow the jury to draw a conclusion about prices.

The evidence of discounting suffers from the same problem identified in the April 1 order: it is not tied to any relevant markets. Plaintiff's experts have not produced information beyond the fact of discounting; they have not shown that discounting took place in the relevant markets (HMO services, primary care, pediatric care and specialty services) identified by the jury at the first trial. Most important, neither in their early reports nor in their Supplemental and Second Rebuttal Reports have they have not disagregated the legal and illegal causes of what they assert are defendant's supracompetitive prices. Other problems exist, such as the questionable comparison of defendant's prices to statewide and Eau Claire average physician prices and Dr. McGuire's insistence on measuring defendants' pricing by patient per year, but these are subsidiary to the basic defects.

Plaintiff argues that it was surprised by the April 1 decision and that it should be given more time to let its experts devise more reports that are responsive to the court's concerns about disaggregation and tying to relevant markets. Its request for a continuance for this purpose is not well founded. The court of appeals made it clear in its 1995 decision that plaintiff would have to show exactly what contributed to the alleged overcharges and establish the portion attributable to illegal conduct. The relevant market question was less clear, but not so improbable a result as to lull a sophisticated litigant such as plaintiff into ignoring it. Plaintiff has had nineteen months in which to consider the implications of the court of appeals' decision and to have its experts prepare to respond to them. Each if its two economists has prepared three extensive reports, including one entitled, "Supplemental and Second Rebuttal," which was filed after the motion for summary judgment had been fully briefed.

That it put all its eggs in one basket is not the fault of defendants or any of the three courts that have dealt with this case. To postpone the trial now, when the parties have expended enormous amounts of time to prepare for it, witnesses have cleared their calendars to be ready to testify and the court has set the time aside, would be unfair to defendants, the witnesses and the court. It would be equally unfair, and an abuse of the purpose of scheduling orders, to let plaintiff adduce new theories of damages at the trial when it has not disclosed those theories to defendants. *Johnson v. Methodist Medical Center of Illinois,* 10 F.3d 1300, 1304 (7th Cir. 1993) ("There must be a point at which a plaintiff makes a commitment to the theory of its case."); *Freund v. Fleetwood Enterprises, Inc.,* 956 F.2d 354, 357 (1st Cir.1992) (trial court has broad legal power to impose sanctions, including exclusion [of evidence], for violations of duty to provide seasonable supplements of information about subject matter of expert witness testimony).

ORDER

IT IS ORDERED that the motion for summary judgment of defendants Marshfield Clinic and Security Health Plans of Wisconsin, Inc. is GRANTED, on defendants' showing that plaintiff Blue Cross & Blue Shield United of Wisconsin would be unable to produce evidence at trial that would enable a reasonable jury to make a reasonable determination of the damages plaintiff suffered as a result of defendant Marshfield Clinic's anticompetitive act of dividing markets in HMO services, pediatric care, primary care and certain specialty care. The clerk of court is directed to enter judgment for defendants and close this case.

APPENDIX H

UNITED STATES DISTRICT COURT
W.D. WISCONSIN

No. 94-C-0137-C

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN
Plaintiff,
v.
THE MARSHFIELD CLINIC and
SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Defendants.

July 28, 1997

OPINION AND ORDER

CRABB, District Judge.

In this civil antitrust case, both sides have filed motions pursuant to Fed.R.Civ.P. 59(e) to alter or amend the judgment entered in favor of defendants on April 8, 1997. The case has a fairly length [sic] history. It was tried once to a jury verdict in favor of plaintiff on all its antitrust claims, including a claim under § 2 of the Sherman Act that defendants had monopolized the health maintenance organization market in north central Wisconsin and two claims under § 1 of the Act of price-fixing and division of markets On appeal, the Court of Appeals for the Seventh Circuit held that the monopolization and price-fixing claims were without foundation but that plaintiff had adduced sufficient evidence to support its claim of illegal market division. The court of appeals remanded the case for a new trial limited to showing how much less Blue Cross would have paid The Marshfield Clinic had the Clinic refrained from dividing markets, *Blue Cross & Blue Shield v. Marshfield Clinic,* 65 F.3d 1406, 1416 (7th Cir.1995), and directed the district court to rewrite the injunction entered after the first trial, limiting it to division of markets.

On remand, after reviewing the evidentiary materials filed by plaintiff in opposition to defendants' motion for summary judgment, I concluded that the evidence plaintiff could adduce at trial was not sufficient to enable a jury to decide how much less plaintiff would have paid had there been no market division. Without such proof, plaintiff could not show that defendants' illegal agreement or agreements had caused plaintiff any injury and, if so, the amount of damages plaintiff had incurred.

Plaintiff wants the court either to vacate the judgment and set the matter for trial, alter the judgments to award plaintiff nominal damages, or alter the motion more extensively, in conformity with plaintiff's motion. Defendants The Marshfield Clinic and Security Health Plan of Wisconsin, Inc. want the court to amend the judgment to clarify the status of the injunction order entered September 10, 1996. Defendants believe that no basis exists for continuance of the injunction now that the court has found that plaintiff is unable to prove two of the essential elements of antitrust liability, causation and damages. In addition, plaintiff has moved for an award of attorney fees and non-taxable costs and defendants have moved to strike the new affidavits, charts and exhibits plaintiff submitted in support of its motion to alter and amend.

Plaintiff bases its motion to amend or alter on four arguments: 1) the Court of Appeals for the Seventh Circuit must have concluded the evidence plaintiff adduced at the first trial was sufficient to show that plaintiff had suffered an antitrust injury as a result of defendants' division of markets; otherwise, the court of appeals would not have directed the district court to rewrite the original injunction to prohibit the defendant Clinic from dividing markets with competing plans or groups. Therefore, argues plaintiff, this court should order an award of nominal damages to plaintiff, even though it has found that plaintiff cannot prove any actual damages. 2) The court acted improperly in granting summary judgment to defendants without making findings of fact and setting out conclusions of law, as required by Fed.R.Civ.P. 56. 3) No motion for summary judgment was pending on April 7, 1997, when the court entered its order granting summary judgment to defendants. 4) The court erred in deciding to grant summary judgment because the evidence demonstrated that the defendant Clinic's division of markets was a substantial cause of actual damages to plaintiff and therefore a direct cause of injury.

Plaintiff's first ground for amending the judgment overlaps defendants' motion to clarify the status of the injunction, making it appropriate to consider them together. Defendants' motion follows from the conclusion I reached in granting summary judgment to defendants: that although plaintiff had adduced sufficient evidence in the first trial to support the jury's finding that it had market power in four markets (HMO's, certain specialty areas, pediatrics and primary care), it had not proven causation and injury related to an illegal division of markets at the first trial and had not submitted evidentiary materials in opposition to defendants' motion for summary judgment that would show how it could make the necessary showing at the second trial. Both causation and injury were critical to plaintiff's success because it had to prove its entitlement to damages under § 4 of the Clayton Act, which authorizes an award of treble damages "to any person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws," but requires a plaintiff to prove causation and injury in addition to a violation of antitrust law. See *Atlantic Richfield Co. v.*

USA Petroleum Co., 495 U.S. 328, 334, 335, 344, 110 S.Ct. 1884, 1889, 1890, 1894, 109 L.Ed.2d 333 (1990) (competitor cannot show antitrust injury merely by showing a *per se* violation of § 1 of the Sherman Act; " 'proof of a *per se* violation and of antitrust injury are distinct matters that must be shown independently' ") (quoting P. Areeda & H. Hovenkamp, Antitrust Law ¶ 334.2c, p. 330 (1989 Supp.)).

In the first trial, the jury was asked only whether defendants had "contracted, combined, or conspired" to allocate customers, territories, or product or service markets. See verdict question 7, dkt. # 476. The jury's answer of "yes" to that question established the existence of an illegal agreement; it did not estabilsh that plaintiff had suffered any injury. In the damages phase of that same trial, the jury found that plaintiff had been damaged as "a direct result of defendants' conduct in violation of the antitrust laws," but did not specify whether the damages were the result of illegal market divisions or were caused by other illegal conduct that the jury had found to be illegal but that the court of appeals held was not. The jury's findings in the first trial were sufficient to show that defendants had market power and that they had engaged in an illegal agreement, enough to establish a *per se* violation, but not enough to carry the day for a private plaintiff proving its entitlement to damages under the Clayton Act. Therefore, I concluded that plaintiff would have to show how the illegal conduct (the division of the markets identified by the first jury) caused it damage. Unfortunately for plaintiff, it had no evidence showing that the market divisions caused it any injury or how much that injury might be if it did occur. Plaintiff's experts did not separate the illegal behavior (division of markets) from defendants' legal behavior or from other factors that might have contributed to the prices defendants charged.

Defendants are correct when they argue that it is inconsistent to conclude that plaintiff cannot prevail on its claim for damages but to continue the injunction in effect. Plaintiff's entitlement to injunctive relief requires the same showing as its claim for damages: that plaintiff has suffered and is likely to continue to suffer antitrust injury caused by defendants' illegal division of markets. Defendants maintain that plaintiff's inability to make that showing means that the injunction should be vacated. The question is complicated by the fact that the court of appeals held that the jury verdict on liability was to stand as it related to division of markets and that this court was to rewrite the injunction issued at the conclusion of the earlier trial, merely restricting its scope to division of markets. Plaintiff argues that when the court of appeals upheld the "liability" finding with respect to a *per se* illegal market division agreement, it was finding necessarily that plaintiff had been injured because the court could not have found liability under the Clayton Act without finding antitrust injury and causation. According to defendants, the liability finding made by the court of appeals was simply one of *per se* liability. Defendants view the court of appeals' directive as based upon an assumption that plaintiff would be able to prove causation and damages, citing *Blue Cross,* 65 F.3d at 1416 ("The burden will be on Blue Cross to show much less it would have paid the Clinic had the Clinic refrained from that illegal practice [dividing markets]"), but maintain that the court would not have expected the injunction to issue or to continue if plaintiff was unable to show any actual injury. No actual injury would mean no liability for defendants under the Clayton Act.

Although the question is not free from doubt, I am persuaded that the court of appeals intended the injunction against division of markets to stand only if plaintiff was able to carry its burden of proving either that it had suffered antitrust injury in fact as a result of defendants' division of markets or that it was in danger of suffering such injury. See e.g., *Cargill, Inc. v. Monfort of Colorado, Inc.,* 479 U.S. 104, 112-13, 107 S. Ct. 484, 490-91, 93 L.Ed.2d 427 (1986) ("Section 4 [of Clayton Act] requires proof of injury 'by reason of anything forbidden in the antitrust laws' § 16 requires proof of 'threatened loss or damage by a violation of the antitrust laws.' "); *Balaklaw v. Lovell,* 14 F.3d 793, 800-801 (2d Cir.1994) ("Regardless of any substantive violation of the Sherman Act, sections 4 and 16 of the Clayton Act still require plaintiffs to establish that the defendants engaged in anticompetitive conduct that caused them an antitrust injury."); *Local Beauty Supply, Inc. v. Lamaur Inc.,* 787 F.2d 1197, 1204 (7th Cir.1986) (Section 16 allows injunctive relief only if plaintiff can show threatened loss or damage by a violation of the antitrust laws). Although these cases address cases brought by competitors of the alleged antitrust violators and turn on the court's determination that the injury they alleged did not flow from "that which makes the defendants' acts unlawful," in the words of the Supreme Court, *Brunswick Corp. v. Pueblo Bowl-O-Mat Inc.,* 429 U.S. 477, 488, 97 S.Ct. 690, 697, 50 L.Ed.2d 701 (1977), the holding seems equally applicable to a plaintiff who fails to show that the antitrust violation produces actual injury.

In view of plaintiff's inability to adduce evidence that would be sufficient to go to the jury on this point, the justification for the injunction disappears. Accordingly, I will grant defendants' motion to alter the judgment to make it explicit that the entry of judgment for defendants does not include the entry of any injunctive relief for plaintiff. I will vacate the order granting such relief that was entered on September 10, 1996.

I will deny plaintiff's motion to alter on the remaining grounds advanced by plaintiff. Plaintiff is not entitled to an award of nominal damages because it cannot prove the prerequisites of antitrust liability (causation and damages), that would entitle it to such an award. As to plaintiff's argument that the court must make more complete findings of fact and determine which of plaintiff's proposals it finds to be undisputed, the vast majority of plaintiff's proposed findings concerned testimony and findings from the earlier trial or propositions set forth in their experts' reports. Little purpose would be served in making findings of fact from these materials. Plaintiff's arguments are dependent on the resolution of questions of law, such as whether the empirical studies in expert reports show that price differentials are substantively affected by defendants' market division agreements and, if so, whether that evidence is sufficient to prove any of the propositions plaintiff must prove in order to prevail on its claim of antitrust injury. They do not depend on resolution of factual disputes.

Plaintiff raises a meritorious point in its third objection, that no motion for summary judgment was pending at the time the order granting summary judgment was entered. Technically, plaintiff is correct. However, when the April 1 and April 7, 1997 orders are considered together, it is apparent that they are both directed to defendants' motion for summary judgment. In the April 1 order, I determined that plaintiff would be required to tie any claim of damages to markets identified in the first trial; in the April 7 order, I concluded that plaintiff would be unable to make this showing at trial. The April 7 order was an extension of the earlier order but both addressed plaintiff's ability to put into dispute at trial the issues on which it bore the burden of proof, specifically, causation and damages.

Plaintiff's attempt to reargue the motion for summary judgment should be reserved for appeal. Rule 59(e) motions are not intended to give the losing party the opportunity to reargue its entire case, *LB Credit Corp. v. Resolution Trust Corp.*, 49 F.3d 1263, 1267 (7th Cir. 1995), or to file new evidentiary material that could have been filed before judgment was entered, *id.*; *Figgie International, Inc. v. Miller,* 966 F.2d 1178, 1180 (7th Cir. 1992). Plaintiff's disagreement with the dismissal of its case does not entitle it to another round of argument or a trial; it had ample opportunity to make its arguments and develop its evidence during the briefing on the motion for summary judgment.

I will grant defendants' motion to strike the evidentiary materials that plaintiff submitted in support of its motion for reconsideration because plaintiff does not suggest that any of these materials include information it did have when the parties were briefing defendants' motion for summary judgment.

Finally, I will deny plaintiff's motion for attorney fees and non-taxable costs. As a nonprevailing party, plaintiff is not entitled to such fees and costs.

ORDER

IT IS ORDERED that the motion of plaintiff Blue Cross & Blue Shield United of Wisconsin to alter and amend the judgment entered herein on April 8, 1997 is DENIED; the motion of defendants The Marshfield Clinic and Security Health Plan of Wisconsin, Inc. to alter and amend the judgment is GRANTED; and the clerk of court is directed to enter an amended judgment, adding to the language of the judgment the following:

> The order enjoining defendants Marshfield Clinic and Security Health Plan of Wisconsin, Inc. from forming or joining any contract, combination or conspiracy concerning the allocation of customers, territories, product or service markets, with any competing plans or groups, including but not limited to North Central Health Protection Plan and declaring void any agreements, understandings and contracts, whether written, oral or otherwise, concerning the allocation of customers, territories, product or service markets, with any competing plans or groups, including but not limited to North Central Health Protection Plan is VACATED. Nothing in the vacation

of this order is intended to permit or authorize defendants to enter into any agreements or combinations that violation the antitrust laws or to immunize them from liability should they do so.

In all other respects, the judgment is to read as entered on April 8, 1997. FURTHER, IT IS ORDERED that defendants' motion to strike the submission by plaintiff of additional evidentiary materials in support of its motion to alter and amend the judgment is GRANTED and plaintiff's motion for an award of attorney fees and non-taxable costs is DENIED.

APPENDIX I

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

Chicago, Illinois 60604

August 25, 1998

Before HON. RICHARD A. POSNER, Chief Judge
HON. WILLIAM J. BAUER, Circuit Judge
HON. MICHAEL S. KANNE, Circuit Judge

Nos. 97-3219 and 97-3847

BLUE CROSS AND BLUE SHIELD UNITED OF
WISCONSIN and COMPCARE HEALTH
SERVICES INSURANCE CORPORATION,
Plaintiffs-Appellants,

v.

MARSHFIELD CLINIC, *et al.*,
Defendants-Appellees.

Appeals from the United States District Court
for the Western District of Wisconsin
No. 94 C 0137 C—Barbara B. Crabb, *Judge*

ORDER

On August 13, 1998, plaintiffs-appellants filed a petition for rehearing with suggestion for rehearing *en banc*. All the judges on the original panel have voted to deny the petition, and none of the active judges has requested a vote on the suggestion for rehearing *en banc*. The petition is therefore DENIED.

APPENDIX J

TITLE 15. Commerce and Trade

Chapter 1. Monopolies and Combinations in Restraint of Trade

§ 1. Trusts, etc., in restraint of trade illegal; penalty

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $10,000,000 if a corporation, or, if any other person, $350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

(July 2, 1890, c. 647, § 1, 26 Stat. 209; Aug. 17, 1937, c. 690, Title VIII, 50 Stat. 693; July 7, 1955, c. 281, 69 Stat. 282; Dec. 21, 1974, Pub.L. 93-528, § 3, 88 Stat. 1708; Dec. 12, 1975, Pub.L. 94-145, § 2, 89 Stat. 801; Nov. 16, 1990, Pub.L. 101-588, § 4(a), 104 Stat. 2880.)

§ 2. Monopolizing trade a felony; penalty

Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $10,000,000 if a corporation, or, if any other person, $350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

(July 2, 1890, c. 647, § 2, 26 Stat. 209; July 7, 1955, c. 281, 69 Stat. 282; Dec. 21, 1974, Pub.L. 93-528, § 3, 88 Stat. 1708; Nov. 16, 1990, Pub.L. 101-588, § 4(b), 104 Stat. 2880.)

§ 15. Suits by persons injured

(a) Amount of recovery; prejudgment interest

Except as provided in subsection (b) of this section, any person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor in any district court of the United States in the district in which the defendant resides or is found or has an agent, without respect to the amount in controversy, and shall recover threefold the damages by him sustained, and the cost of suit, including a reasonable attorney's fee. The court may award under this section, pursuant to a motion by such person promptly made, simple interest on actual damages for the period beginning on the date of service of such person's pleading setting forth a claim under the antitrust laws and ending on the date of judgment, or for any shorter period therein, if the court finds that the award of such interest for such period is just in the circumstances. In determining whether an award of interest under this section for any period is just in the circumstances, the court shall consider only—

(1) whether such person or the opposing party, or either party's representative, made motions or asserted claims or defenses so lacking in merit as to show that such party or representative acted intentionally for delay, or otherwise acted in bad faith;

(2) whether, in the course of the action involved, such person or the opposing party, or either party's representative, violated any applicable rule, statute, or court order providing for sanctions for dilatory

behavior or otherwise providing for expeditious proceedings; and

(3) whether such person or the opposing party, or either party's representative, engaged in conduct primarily for the purpose of delaying the litigation or increasing the cost thereof.